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ABSTRACT

Findings of a New Jersey survey of existing services in the health, education, and welfare sectors concerned with early pregnancy and childbearing are presented with relevant recommendations in this document. Results from interviews with 25 key state officials, prominent program directors, and community leaders as well as from a formal survey of 111 schools, community agencies, county welfare agencies, and Division of Youth and Family Services district offices constitute the major source of data. Four aspects of service operationalized by survey questions are identified: linkage, accessibility, training, and evaluation. Findings and recommendations in the area of preventive services include discussions of the Family Life Education Program, school-community linkages, and family planning within the county welfare agencies. Findings in the area of treatment services looks at linkages, accessibility of services, training of staff, and evaluation. Findings and recommendations are also discussed in the area of needs unmet by any agency. Because of the lack of coordination of services revealed by the study, the designation of a state department as a lead agency is recommended and suggestions are made on how to deal with the problems of adolescent pregnancy. An overview of other states' legislative trends and a bibliography are included. (ABL)

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A BLUEPRINT FOR ACTION IN WORKING WITH PREGNANT AND PARENTING ADOLESCENTS

AND THOSE AT RISK

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The Association for Children of New Jersey (ACNJ) is an organization of volunteers that advocates for policies and programs on behalf of children. ACNJ does not provide direct services. Its major goals are:

- To be a voice for families and children
- To promote policies and programs for the protection and well-being of children
- To monitor laws and programs to assure that children's needs are a priority, and that public funds are used fairly and effectively
- To plan for the needs of the next generation.

ACNJ has a rich history of concern for children dating back to 1848 when its original predecessor, the Newark Orphan Asylum, was founded. Building on its past, ACNJ has been highly effective in working for reforms of laws and practices through a myriad of advocacy efforts including innovative research; analysis of public policy; monitoring and evaluation of programs; and mobilizing constituencies to action. ACNJ's program focuses on national, state and local issues and concentrates its efforts on the level(s) which would be of most benefit to children.

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The New Jersey Network on Adolescent Pregnancy (NJNAP) is a program of the Center for Community Education of Rutgers School of Social Work. The Center provides a portion of the public service delineated in the mission of Rutgers-The State University. Specific functions of the Center are to provide a bridge between the University and the community by the identification of current and emerging public issues and to utilize University and other resources to assist in seeking solutions; and to provide organizational leadership and educational support in social problem-solving and public policy development.

The Network, created in 1979, is a voluntary association of organizations and individuals focusing on the issue and its ramifications. Activities of the NJNAP are carried out on the local level, in County Networks. The Network provides linkages among existing organizations but is not itself a formal organization with membership as such; it consists of affiliates and subscribers who are seeking ways to share information and ideas; it provides a common focus on serving adolescents in need without limiting freedom of choice in the type of service provision; it emphasizes the enrichment of sharing and mutual cooperation, particularly during funding cutbacks; and it seeks to avoid duplication and competition. By mid-1986, almost 3,000 people had joined together in activities of the County Networks.

The Rutgers office of NJNAP exists to provide services to the County Networks and their affiliate agencies. Rutgers provides technical assistance and consultation; a quarterly newsletter EXCHANGES; statewide and county resource directories; seminars, conferences and training; a resource center of printed and audio-visual materials; and clearinghouse services about program and policy development and statewide planning to persons concerned about adolescent pregnancy, teen parenting and related issues.

No Easy Answers:

A BLUEPRINT FOR ACTION IN WORKING WITH PREGNANT AND PARENTING ADOLESCENTS AND THOSE AT RISK

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Preface

The Association for Children of New Jersey (ACNJ) and the New Jersey Network on Adolescent Pregnancy (NJNAP) are deeply concerned about the consequences of too-early pregnancy and childbearing. In an effort to stimulate broader interest in finding solutions, the two organizations initiated a collaborative project in 1985 that surveyed existing services in the health, education, and welfare sectors. This report is unique in that we explored four critical factors in service delivery: accessibility, linkage, staff training and program evaluation.

The result of this project is this report outlining additional steps that policy makers, service providers and advocates can undertake to strengthen prevention and intervention efforts. Our project is consistent with national interest in adolescent pregnancy spearheaded by the Children's Defense Fund's Adolescent Pregnancy Child Watch Project.

Although this report refers to model programs throughout the country, most of the discussion is grounded in New Jersey's experience. Interviews with 25 key state officials, prominent program directors and community leaders as well as a formal survey of 111 schools, community agencies, County Welfare Agencies and Division of Youth and Family Services District Offices constitute the major sources of data.

ACNJ and NJNAP gratefully acknowledge the contribution of those who participated in the study and acted as volunteer interviewers. Their names are Grace Brown, Audrey Alvarez, Mildred Boone, Miriam Cannel, Dr. Behnaz Pakizegi, Kathy Thompson, Linda Harris, Harriet Bloomfield and Susan Egbert. We also thank those who gave of their time and consented to be interviewed, and hope that this report will assist them in their important advocacy work.

We would also like to thank Ann M. Wilson, Director of NJNAP, and Ciro A. Scalera, Director of ACNJ, for their help in terms of overall guidance and editorial assistance to the project, and Estelle R. Robinson of Rutgers Center for Community Education and members of the Boards of both organizations for their review and input on this document. Our thanks go also to Tricia Fagan for her editing work on the Introduction. Finally, we would like to acknowledge ACNJ staff members Sue Conti and Cecilia Zalkind for their general review and assistance, Antoinette Abdelmalek for her typing of the questionnaires, and Marilyn Fuentes for wordprocessing work on the report.

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SUE CONTI (p. 19).

Myths vs. Reality:
Refuting Some Common Misconceptions

MYTH Teenagers who get pregnant are promiscuous.

FACT More than one-fifth of first premarital pregnancies among teenagers occur within the first month after the initiation of sexual intercourse; half of these pregnancies occur within the first six months (Alan Guttmacher Institute, 1981).

MYTH Family Life Education encourages teens to be sexually active.

FACT Sex education is not associated with increased sexual activity among teenagers. In some instances, sex education has been found to be associated with more effective contraceptive use among teens. Adolescents also report better communication with their parents as a result of Family Life Education (Zelnick, 1982; Kirby, 1985).

MYTH The availability of contraception encourages teens to be sexually active.

FACT Only one-third of sexually active teenagers report consistent use of contraceptives (Alan Guttmacher Institute, 1981). If the availability of contraception exerted a strong influence on teens' sexual behavior, the use of contraception would have had to precede sexual activity. The data do not bear this out — most teens do not use contraception until almost a year after initiating sexual activity.

MYTH Welfare benefits offer an incentive for teens to bear children outside of marriage.

FACT The fertility rates of teenagers are actually lower in states and foreign countries which provide more generous levels of public assistance for the poor (Jones, 1985; Pittman, 1986).

MYTH Teenage fathers are uncaring victimizers who contribute nothing to the well-being of their children.

FACT Many young fathers maintain relationships with their children, making financial and in-kind contributions when possible. They are often forced out of their children's lives. Conflict with the teen mother and her family often arises because unemployment and lack of marketable skills render them unable to fulfill the traditional male role of provider (Sander, 1986).

MYTH Offering child support services to teenage parents encourages early childbearing.

FACT Support services reduce the numbers of subsequent pregnancies among teenage mothers and increase school completion and employability (McGee, 1982; Polnit, 1985).

Executive Summary

I. A NEW STATE APPROACH TO ADOLESCENT PREGNANCY

Findings
Present community and state efforts lack coordination, overall planning and systematic evaluation. Agencies and state departments are limited by their traditional service and professional boundaries. The system in place, based upon categorical needs of children and adults, is unable to develop services appropriate to the adolescent.

Recommendation
That a state department be designated as the lead state agency and be funded as an *Office of Adolescent Services*, with an appropriation of $250,000, to develop a coordinated, comprehensive approach addressing adolescent pregnancy and teen parenting. This office would deal with the problem as an organic whole and develop age-appropriate services to adolescents.

II. HIGHLIGHTS OF FINDINGS AND RECOMMENDATIONS — FROM A SURVEY OF 111 AGENCIES AND 25 PUBLIC OFFICIALS/COMMUNITY LEADERS

A. Preventive Services

1. The Family Life Education Program (FLE)

Findings
- All school districts examined were teaching FLE at both elementary and secondary levels, covering all topics but not in all classes, and all programs involved parents in the development of curriculum;
- Two-thirds of the schools taught the subject of contraception in at least one high school grade;
- Over half of the respondents cited as an advantage the fact that parents accepted the program;
- Should funding become available, respondents felt that priority should be given to teacher training, acquiring additional classroom supplies and resources, and hiring new staff;
- Very few evaluated their programs.

Recommendations
- That schools not presently incorporating the subject of contraception in grades 7 through 12 make every effort to do so;
- That opportunities for teacher training be expanded; that FLE certification eventually be instituted to ensure a common knowledge base and shared teaching approaches;
- That routine evaluation be carried out by FLE teachers and/or supervisors in order to improve programs.

2. School-Community Linkages

Findings
- Most FLE programs invited speakers from community groups and agencies to augment class presentations;
- In one district surveyed, Medicaid's[1] Early Periodic Screening, Diagnosis and Treatment Program (EPSDT) was conducted in the schools since more than half of the children were eligible;
- As of this writing, there are no school-based health clinics operating in New Jersey.

1 Medicaid is a federal-state program of medical care for the very needy.

Recommendations

- That local school districts learn about and make greater use of already existing community programs, both public and private, enabling school personnel to make appropriate resources available to students;
- That EPSDT services be brought into school districts that have substantial numbers of eligible children and that reproductive health services for the teenager be incorporated;
- That the feasibility of developing school-based health clinics within high-risk schools and/or school districts be explored by the state.

3. Family Planning Within County Welfare Agencies

Findings

- No consistent pattern of discussing family planning with clients during recertification for Aid to Families with Dependent Children (AFDC) was found among County Welfare workers;
- Some respondents felt that both their Family Planning Unit and the Medicaid EPSDT program could play bigger roles in encouraging family planning and preventing teen pregnancy;
- Several respondents indicated that private physicians were unwilling to provide obstetrical/gynecological services to Medicaid patients, a critical situation in rural counties lacking subsidized medical clinic services.

Recommendations

- That funding for family planning services be increased in order to expand services and reach more needy women:

  a) That additional state/private subsidies be given to family planning agencies and clinics;
  b) That Medicaid fees be increased so that more private physicians participate and also to fully cover the cost of services by family planning clinics so that their other funding sources do not have to be used to subsidize the Medicaid program;
  c) That school-based clinics be instituted which can refer teens for family planning when necessary;
  d) That EPSDT programs include reproductive health care for teens;

- That methods to encourage AFDC clients to use family planning be explored and incorporated; that educational programs, films and brochures be made available during waiting-room time; that Public Welfare look into improved data collection in order to facilitate the targeting of vulnerable teens for specific outreach efforts; that care be taken so that the use of family planning is not perceived as a threat, tied to the continuation of AFDC.

B. Treatment Services

Four operational aspects of the programs of sample agencies were examined: Linkages, Accessibility, Training and Evaluation (LATE).

1. Linkages

- Approximately a third of the agencies made few referrals;
- Verification that services to which the client had been referred had actually been given was not consistently done;
- Respondents indicated that the lack of follow-through by the adolescent client was the most frequent problem;
- Agencies with the most rigorous follow-up practices (verifying the receipt of services) reported fewest referral difficulties.

Recommendations

- That referral practices be enhanced in all agencies.
- That verification showing that services have been/are being given should become an integral part of the referral process.

2. Accessibility of Services

Findings

- *Transportation* – The majority of community agencies did not provide transportation even though teens cannot lawfully drive; DYFS and County Welfare sometimes provided carfare;
- *Outreach* – Two-thirds of the community programs did not assign staff to conduct outreach; less than a third engaged the young mother's family and only about a tenth included the father in programs;
- *Intake* – Only about one-fifth of the providers used a comprehensive intake interview that could enable the development of an adequate treatment plan;
- *Parenting Classes* – Over half of the community agencies offered classes in parenting skills although many had no written curriculum; nutrition was the topic most often taught and family planning and providing for child care least often;
- *Timeliness of AFDC/Medicaid* – Six of the County Welfare Offices required birth certificates when applying for newborns before AFDC (cash benefits) and Medicaid (medical assistance for the needy) were issued, even when income and assets were not at issue. Other Offices allowed the temporary acceptance of other identification called "presumptive eligibility," so that the infant's medical care would not be delayed;
- *"Deeming" – Problems of Eligibility for AFDC/Medicaid* – "Deeming" of income (see text for explanation) was judged by County Welfare personnel to have resulted in: 1) more teens setting up their own households; 2) more teens dropping out of school; 3) a decline in family supports for adolescents who were pregnant/parenting.

Recommendations

- *Transportation* – That programs operate some form of transportation for teen clients or automatically pay carfare;
- *Outreach* – That outreach efforts targeted to adolescents be routinely incorporated into the various programs; that both the mother's family and the young father be involved whenever possible, because of the value of their support;
- *Intake* – That comprehensive intake be used by all service providers when interviewing new clients so that appropriate plans and referrals can be developed;
- *Parenting Classes* – That agencies not presently offering parenting classes attempt to add this service; that written curricula be developed so that course content is not dependent on the talents of individual teachers;
- *Timeliness of AFDC/Medicaid* – That the State Division of Welfare officially inform each County Welfare Office that "presumptive eligibility" should be extended to all newborns eligible for AFDC and monitor the manner in which this is being carried out; that the new Medically Needy Program of Medicaid also be modified in this way for newborns;
- *"Deeming"* – That all advocates mount campaigns on both the federal and state levels to modify the "deeming" policy because of its extremely negative effects.

3. Training of Staff

Findings

- Half of those interviewed reported that they had received no staff training in the past year in adolescent sexuality and development; of those receiving training, only four had been exposed to both subjects.

Recommendation

- That staff training be routinely offered by every agency working with pregnant and parenting teens, and that it include both adolescent sexuality and development.

4. Evaluation

Findings

- The majority of respondents did not monitor important elements of outcome; less than a quarter even kept track of the number completing their service.

Recommendation

- That all programs monitor the numbers of teens completing their service, graduating high school and becoming employed as well as the number of repeat pregnancies and the birthweights of infants born to teen clients. That technical assistance in evaluation procedures, analysis of data and planning be provided on a regional/state-wide basis by state agencies, universities, etc.

C. Unmet Needs

Findings

- Major service gaps were judged to be Housing, Infant Child Care, Parenting Education and Services to Teen Fathers;
- Two-thirds of the responding agencies felt that they could *not* meet housing needs for pregnant and parenting teens even if given additional resources;
- Over half said they could meet child care needs with the infusion of additional resources;
- Most respondents said that they could develop classes on parenting and giving services to teen fathers, with the resources already on hand.

Recommendations

- That a state initiative be instituted to provide housing alternatives — foster placements, group homes and semi-supervised independent living arrangements — specifically for pregnant and parenting adolescents who need shelter;
- That infant day care slots be opened for parenting teens on the condition that they remain in or return to school until graduation or receiving a GED;
- That local schools, under the leadership of the State Department of Education, gather information relating to adolescent pregnancy in a systematic, on-going fashion;
- That parenting classes and services to teen fathers be developed, following recommendations of the previous sections.

INTRODUCTION

The causes and results of adolescent pregnancy have been the focus of renewed debate and concern in New Jersey during the past few years. At issue for policy makers, service providers and concerned citizens is how teenage pregnancy can be prevented and, for those adolescents who are already parents, how best to provide them with the resources they need to move forward into healthy, productive lives.

The state of New Jersey has obvious reason for concern. The most recent available statistics show that almost 10% of all infants born in New Jersey in 1984 were to adolescents age 19 or younger. Most of these teen births occur to adolescents who are single. In 1983, this figure was 73%, second highest among all states in the nation (Children's Defense Fund, 1986b).[1]

While some may attribute this phenomenon to a decline in the influence of social and religious institutions and accompanying sexual constraints, it is important also to note that today's adolescents reach physical maturity at a much younger age than their historical counterparts. At the end of the American revolution, the average onset of menstruation was 17; by 1900, it was 13.5; and by 1980, it was 11 years, 10 months. Moreover, it is estimated that in each future decade, the average age of menstruation will decrease by another four months. Since developmental patterns for males have not been monitored, it is not known whether there has been a similar decline in their average age of sexual maturation during the same timespan.

The foregoing poses a startling dilemma - earlier physical maturation at the very time when entry into adult society is being increasingly delayed, the stage of dependency is being prolonged and jobs enabling an adolescent to support a family are either not available or require the kind of sophistication and skill a teen has not yet acquired. How we respond to this dilemma is critical in our efforts to deal with unwanted pregnancies.

Contrary to preconceptions, adolescent pregnancy affects almost every socio-economic, ethnic and religious group. More than 30,000 teenagers from throughout New Jersey will become pregnant this year. According to the current trend, more than two-thirds of these young women will choose to end their pregnancy with an abortion. They will do so for a variety of personal, social and fiscal reasons. A great many of these teens will come from more financially well-off families. National data indicates that for every adolescent who gives birth, one will have terminated her pregnancy. New Jersey's abortion rate is higher than the national average (Henshaw, 1985).

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[1] A very recent survey of 1984 data by the National Center for Health Statistics shows that for the nation as a whole, birthrates of unwed teens and younger women have declined while those for unwed women in their 30's and 40's have increased. As of this date statistics for New Jersey alone were not available. (National Center for Health Statistics, July 18, 1986.) These data, however, do not diminish the seriousness of the problem, because of the severe effects of early child bearing upon adolescents and their families.

Far more visible, however, are those adolescents who actually give birth. In 1984 there were 10,294 infants born to mothers 19 years old or younger. Of these, 850 were to mothers 15 years old or younger. A disproportionate number of teenage births were to non-white adolescents. Although New Jersey's non-white population constitutes about one-quarter of the total, 46% of teen-age births were to minority adolescents.

The majority of teenagers who give birth choose to keep their babies rather than place them for adoption. Seventy percent of them will raise their children as a single parent (Children's Defense Fund, 1986 b). As a result of this choice, most of these adolescents are relegating themselves and their young families to lives of poverty and hardship. All along the way, the fact that they made certain choices, sometimes by not actively choosing, marks them as prime candidates for lives of deprivation.

Female-headed households are more likely to be poor than any other family group. Their children are more at risk of health, learning and social pro-blems (Moyhihan, 1985). National statistics indicate that 6 out of 10 women dependent on grants from Aid to Families with Dependent Children (AFDC)[1] gave birth while they were teenagers (Alan Guttmacher Institute, 1981).

Adolescent pregnancy is clearly related to poverty. Rural, predominantly white Cumberland County has both the highest rate of adolescent fertility and the lowest per capita income of all the counties in the state. Atlantic, Essex, Passaic, Hudson and Camden Counties follow closely. Each contains urban centers with large pockets of poor, primarily minority citizens (NJ State Department of Health, 1985).

For those teenagers who seek AFDC support, current low welfare levels and negative welfare policies tend to exacerbate an already difficult situation. Many policy makers argue that the availability of public assistance has created an incentive for poor women, particularly teenagers, to bear children outside of marriage. In reality, the opposite appears to be true. Countries with rates of adolescent pregnancy lower than the United States generally have a more generous level of benefits that usually include medical care, food supplements, housing and family allowances (Jones, 1985). Nationally, the proportion of births to teens is actually lower in those states with public assistance support that allows a more adequate standard of living for poor families (Children's Defense Fund, 1986).

The lives of these young mothers and their children are also jeopardized by risks related to early child bearing, an adolescent reluctance to seek care and a lack of subsidized or low-cost prenatal care in certain parts of the state. For example, low birthweight (less than 5 1/2 pounds) is the strongest correlate of infant illness, death and mental retardation. Unfortunately, teens are at greatest risk of delivering low birthweight infants. In 1984, almost 20% of infants born to New Jersey teens under 15 and almost 11% of those born to mothers 15 to 19 were in the low birthweight category. This contrasts with only about 7% for babies born to all mothers in 1984.

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[1] AFDC is the federal-state program providing cash grants to very needy families with children under 18, primarily headed by women. Recipients are also enrolled in Medicaid, a medical program giving in- and out-patient care.

Because of this known risk, optimal prenatal care (i.e., beginning in the first trimester) is considered a necessity. However, in 1984, only 41% of the state's pregnant adolescents under 15 and 55% of those aged 15 to 19 received such care. In contrast, 80% of women of all ages began care in the first trimester. This type of problem extended to the numbers who did not see the doctor at all. Almost 5 1/2% of those under 15 and 2% of those 15 to 19 received no care at all during the nine months of their pregnancies against less than 1% for all pregnant women (NJ State Department of Health, August 6, 1986).

Added to the immediate problems of delivery are educational difficulties. The potential economic self-sufficiency and personal future of these school-age mothers is highly dependent on whether or not they complete their education (Dryfoos, 1985; McGee, 1982). Currently, although schools may attempt to educate an adolescent through her pregnancy, few focus on continuing that education through to graduation. In reality, a teenage mother needs infant and child care services and additional supports such as parenting education if she is to successfully pursue her diploma and move towards personal and economic self-reliance.

To date, New Jersey has failed to develop a comprehensive policy or service delivery system to address the issue of adolescent pregnancy. In part this is due to the large complex of agencies and systems, both private and public, that currently provide or could potentially provide needed services to this population of teenagers. Without coordination and an integrated approach, the needs of pregnant and at-risk adolescents will not be effectively met.

This failure to act is also due in part to the conflicting, often ill-defined and very emotional value judgments that society brings to the issue of teenage sexuality. The fact is that despite conflicting public opinion, sexual experimentation is, and has always been, a normal part of growing up. Psychologists emphasize that one of the most important tasks of adolescence is to establish intimacy with people outside the family circle (Erikson, 1950; Blos, 1968). For many (if not most) young people, this includes exploring physical as well as social and emotional closeness with others.

There are opponents of family planning and contraceptive services for adolescents who argue that access to these services encourages sexual activity among teenagers. A national survey, however, indicates that only one-half of sexually active teenagers surveyed used birth control at first intercourse and only one-third reported consistent use of contraception (Alan Guttmacher, 1981). This suggests that access to contraception is by no means the primary consideration for teenagers when they choose to be sexually active.

Some claim that simply providing adolescents with <u>information</u> about their sexuality and the use of contraception encourages them to be sexually active. Again, research data (Zelnick, 1982; Kirby, 1985) demonstrates that this is not true. To the contrary, it has been shown that sexual education is frequently associated with more effective use of contraception and a lower risk of pregnancy for those young people who have already chosen to be sexually active.

In fact, the old adage "an ounce of prevention is worth a pound of cure" is most appropriate when speaking of adolescent pregnancy. For the adolescents involved and their families, the personal cost of bearing a child is heavy. The public costs, however, in terms of the direct medical and social services needed and the long-term economic dependency of teenagers whose educations have been cut short,

are staggering. By focusing the necessary human and fiscal resources on effective prevention programs, these costs, both personal and private, could be reduced significantly.

For example, the Center for Population Options has just published an estimate of the costs of teenage pregnancy (Burt, 1986). They figure that the average public savings in the U.S. from delaying child bearing until the mother reaches 20 would be over $6,250 per birth. In New Jersey alone, based on this figure, we estimate that if each birth to a teenager in 1984 had been delayed in this fashion, the total savings would be $50 million. Moreover, the same study estimated that in 1984 in New Jersey over $410 million worth of public assistance went to families headed by women who had given birth to their first child while still a teenager (Burt, 1984).[1]

The importance of societal commitment toward the prevention of unintended pregnancy and childbearing among teenagers has been persuasively documented by an international study conducted by the Alan Guttmacher Institute (Jones, 1985). Comparison of the United States with five European countries with similar cultural backgrounds and in a comparable stage of economic development revealed that the United States had rates of pregnancies, abortions and births to women under age 20, 2 to 5 times higher than any of the other countries.

The Guttmacher researchers concluded that the substantially lower pregnancy rates were not due to a difference in the levels of sexual activity, but rather to the implementation of national policies that included an emphasis on comprehensive sex education and access to contraceptive services to teenagers. Sweden and France have been particularly successful. Sweden, for example, put a great deal of effort and expertise into developing a uniform sex education curriculum that was implemented throughout the country. Since that time, the rates of pregnancies, births and abortions to Swedish teenagers have been significantly reduced.

New Jersey made a significant attempt at primary prevention when it adopted the policy requiring Family Life Education to be provided to all students in the state's public schools. The New Jersey State Board of Education has taken a bold and thoughtful first step in addressing adolescent pregnancy and other problems facing teenagers and has put our state in the forefront of the nation through this initiative.

Family Life Education in New Jersey is designed to provide a well-rounded introduction to human relationships, personal problem solving, family interaction and parenting skills along with age-appropriate information on human sexuality and contraception options. It is programmed towards enhancing and encouraging parental involvement, and attempts to provide a balanced perspective to counter the too-familiar media portrayal of sexual relations as encounters between unmarried partners that are exploitative, uninvolved and often violent.

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[1]For an article on the public costs of adolescent pregnancy based on the report from the Center for Population Options, please contact ACNJ.

Family planning services are an important preventive service. Though these services can be found throughout the state, they may not always be accessible to the teenage population. The importance of clinic location, hours of operation, fees, outreach and education must be recognized and acted on if these services are to be as viable a tool in the prevention of teen-age pregnancy as possible. Accessibility and familiarity with the health-care system can remove many of the social, psychological and financial barriers to responsible contraceptive use among young men and women who have already made the decision to have sexual intercourse.

With regard to services for adolescent parents, society must recognize the special needs of our youngest parents. The support of their own family is of primary importance. However, the human service, health and education communities must be prepared to fill the basic financial and human support needs of the adolescent parent towards helping them eventually assume mature responsibility for themselves and their children.

Ultimately it will be our teenagers who, with our guidance and support, must make the choices that will prevent adolescent pregnancy. These choices will take many forms. Those adolescents who choose to delay initiation of sexual intercourse must be supported and encouraged to follow their inclinations to say "no." All teenagers need to be helped to understand both the risks and responsibilities of human interaction, particularly sexual involvement. They should also be made aware of the internal and external pressures that influence their life choices.

For those of us interested in preventing adolescent pregnancy, our most challenging task is to instill a sense of hope in our youth. We must provide them with dreams as well as opportunities for achievement and realization of their self-worth in ways other than through premature sexual involvement and adolescent parenthood.

This is a formidable, though not impossible, task. It requires not only the coordination of multiple services and the redefining of social attitudes and roles, but also demands that we address the broader issues of poverty, racism, education and unemployment that create the quiet despair which so harshly limits the future goals of so many of our young people.

New Jersey must move even more forcefully in addressing this issue. An effective, comprehensive policy of prevention and positive support must be developed if the problems of adolescent pregnancy and parenthood are to be resolved. In the end, it is up to us. Our children will not fail us unless we fail them. They can only become who we allow them to be.

STUDY DESIGN AND METHOD

This study was designed to collect detailed information on the way in which New Jersey agencies in the field of adolescent pregnancy are attempting to meet the specific needs of their young clients and also to give a sense of the types of such services being provided. It draws upon the experience of New Jerseyans working with adolescents in the areas of pregnancy prevention, pregnancy services and teen parenting, and touches upon both public and private sectors.

Interviews were conducted in two stages. The first - during the spring of 1985 - was undertaken in order to get a broad, state-wide perspective of the problem and to aid in the development of the questionnaire to be used in the survey. The second - between June and November, 1985 - was conducted with individuals working with adolescents in the field in order to gather detailed information from agencies currently in operation.

The initial interviews were held with 25 senior public officials and community leaders, representing state and local agencies in health, employment, law enforcement and human services as well as social service administrators, researchers and academicians. Each respondent was asked for their views on how to prevent adolescent pregnancy as well as how to strengthen existing services for pregnant and parenting teens.

The second round of interviews was held with a total of 111 individuals representing schools, community agencies, district offices of the Division of Youth and Family Services (DYFS), and County Welfare Offices (CWA's). It should be noted that this does not comprise an exhaustive list of all agencies or service providers working in this field. Rather, the sample was chosen for the following reasons: 1) The schools and community agencies represent a broad range of the health, educational and social services offered in the state and therefore give a fairly comprehensive picture of the type of services available and the way in which they are operating; 2) the DYFS District Offices and CWA's (all of which were included) serve many adolescent parents and their families of origin and therefore are able to contribute essential information on the manner in which public services - be they in the nature of financial support or treatment - are being given; 3) the Family Life Education programs are divided between urban and non-urban areas and the community agencies represent every county except Cape May, so that geographic and demographic variables have been included among those examined.

Of the 111 respondents to our survey, 24 were school personnel including 14 teachers and administrators responsible for Family Life Education (FLE) and 10 administrators from school programs for pregnant teens. Of the 46 community agencies, almost half (20) had a major thrust towards preventive services, while slightly more than half (26) were primarily focused on treatment services for pregnant and parenting teens. About 3/4 (35) received some funding from the State Department of Health and 18 received foundation support. In addition, seven received funding from DYFS and another five received funding from the Division of Public Welfare.

As mentioned above, all CWA's and DYFS District Offices were included. Within the CWA's, one or more administrator responsible for services was usually interviewed. Within the DYFS offices, the District Office Manager and/or the Resource Development Specialist were usually interviewed.
The interview schedules included both open-ended and closed questions. Respondents were asked to describe clients, the kinds of services being offered and their staffing arrangements. In addition, all respondents were asked about four aspects of their work common to all: the linkages they provided; the accessibility of their services; the staff training that was offered; and whether and what type of evaluation of services was undertaken. These four issues were emphasized because they have practical implications for policy development and service delivery.

Specifically, these four aspects of service were operationalized by questions dealing with the following subjects:

LINKAGE - The referral process of the agencies; the frequency with which agencies referred to 15 specific services;[1] the extent to which agencies verified that clients used the referrals;[2] collaboration or the extent to which agencies engaged in joint programming and/or planning around adolescent issues.

ACCESSIBILITY - The agencies' hours of operation; whether or not transportation was provided and/or available; the extent to which outreach was undertaken and the staff involved;[3] the intake practices of the agencies and the availability of services to family members and partner.

TRAINING - The extent of training to staff;[4] the degree to which human sexuality and adolescent development were included.

EVALUATION - The extent to which five key outcomes were monitored: the number of clients completing services, graduating high school, being employed; in case of a delivery, the birthweight of the infant and whether this was a repeat pregnancy; or in the case of evaluating a preventive service, whether there was a first pregnancy.

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[1]These included abortion, adoption,child care, contraception, counseling, financial assistance, food stamps, foster care, parenting classes, pediatrics, pregnancy testing, prenatal care, residential services, vocational training and WIC.

[2]These characteristics of the referral process were considered important because the frequency suggested the degree to which linkages were being initiated, and verification of the referral suggested the kind of commitment service providers made to ensure that clients were actually linked with needed services (Williams, 1981).

[3]It is generally understood that adolescents are reluctant to use services. Therefore, the ability of agencies to put outreach workers in the field to encourage teens to use their service can be considered as an indicator of service accessibility.

[4]Training is generally recognized as an important element of staff support in addition to being a way to build specific skills.

The interviews were conducted by the two project staff, six community volunteers and four student interns in university-level human service programs.[1] All interviewers were trained and closely monitored. In general, the interviews lasted one hour.

The diversity of the study sample required some modification to the questions concerning the four aspects of service listed above. All 111 respondents were asked about the availability of staff training in the areas of human sexuality and adolescent development. All 20 respondents providing agency-based prevention services and the 77 respondents from education, health and social service settings providing treatment services were asked the same questions about accessibility, linkage, staff training and evaluation.

However, the 14 respondents working in FLE programs were not asked about accessibility, since their programs were school-based and open to all students. Similarly, questions about referral were omitted, because these were usually made by other school personnel - the nurse, guidance counselor or social worker. FLE respondents were asked, however, about the extent to which they worked with others on joint and/or collaborative planning. Finally, questions about evaluation practices were modified for the 14 FLE respondents, because we recognized that evaluation outcomes pertinent to agency-based services were not appropriate to services given in schools (Kirby, 1985). Rather, we asked respondents whether they had undertaken any evaluation and whether they thought certain evaluative approaches were feasible.[2]

[1]The names of these volunteers, who successfully carried out an assignment requiring much time and effort, can be found in the Preface.

[2]Copies of the five versions of the questionnaire (Community Agencies, County Welfare Agencies, Division of Youth and Family Services, Family Life Education Programs, and School Programs for Pregnant Teens) are available from ACNJ.

PREVENTIVE SERVICES: FINDINGS AND RECOMMENDATIONS

The following two sections summarize the findings of this study that examined agencies currently working in the field of adolescent pregnancy. This chapter deals with preventive services; the next deals with treatment services. As indicated in the previous section, four specific aspects of service operation were emphasized -- linkage, accessibility, staff training and evaluation -- and, to a large extent, all study respondents were asked the same questions about these operational characteristics. In order to avoid repetition, discussion of these issues is included in the next section since a majority of respondents fell into the treatment category.

This section on preventive services discusses three topics: Family Life Education (FLE) programs, community-school linkages and family planning services to teens considered to be most vulnerable.

I. FAMILY LIFE EDUCATION (FLE) PROGRAM

OVERVIEW

Family life and sex education programs have been credited as being one of the important reasons why many developed European countries have lower adolescent rates of birth, abortion and pregnancy than the U.S. (Jones, 1985).[1] In this country, a study in Baltimore found that teens who participated in a special sex education program refrained from engaging in sexual activities longer than those who were not in the program. The report by Johns Hopkins University researchers indicates that a program including an extensive sex education component is very effective not only in reducing the age of sexual activity but also in decreasing pregnancies (Zabin, 1986).

Findings such as these support the policy of teaching in this area in public schools. New Jersey is frequently cited as a leader in school-based sex education since it is the only state in the country to establish a life education program that is more comprehensive than sex-education per se (See following paragraph). The state's policy requiring that FLE be given to all students in public school is the most significant statewide attempt at primary prevention, reaching over one million students. Moreover, since all youngsters under 16 regardless of ethnicity or socio-economic status are required to attend school and may therefore receive FLE instruction, it is a non-stigmatizing program with a strong potential for affecting values and behaviors within the entire youth community.

The FLE administrative policy mandates the teaching in all public school districts of interpersonal relations, human sexuality and development, decision making and family life. It also provides for community involvement

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[1] See the Introduction for a brief discussion of a cross-national study of the Guttmacher Institute that compared American adolescent rates of pregnancy, abortions and births with those of five European countries of similar socio-economic development. It was the researchers' contention that comprehensive sex education and access to contraceptive services were important determinants of the substantially lower European rates.

in the development of the curriculum and it has a student excusal policy with accompanying procedures.[1] Parents can decline to have their child participate if they so wish. The program, implemented in 1983, was readopted in March, 1985, for another five years.

Full responsibility is given to local school districts for curriculum development. There is substantial flexibility in designating teachers, with those teaching in the following subject areas qualified to take part: biology, comprehensive science, health and physical education, home economics, psychology and special education. Also included are school nurses and all elementary and nursery school teachers.

Worth noting is the fact that there is no certification procedure for FLE instructors and no standards or requirements for teacher training. Thus, there is no guarantee that FLE teachers in New Jersey's 611 local districts have a common knowledge base or teaching approach.

FINDINGS ABOUT FLE PROGRAMS

Interviews were held with 14 FLE teachers or their supervisors, half of whom taught in urban and half in non-urban programs.

1. All districts examined were teaching FLE at the elementary and secondary levels at the time of the survey in fall, 1985.[2]

2. All respondents stated that the topics identified in the Code were being taught, although not all topics were taught at each grade level.

3. Ten of the 14 respondents (about 2/3) stated that contraception was discussed in at least one high school grade.

4. Ten of the 14 (about 2/3) reported that parents were given an outline of their child's course, that at least one general meeting to discuss curriculum had been held, and that parents had been involved in curriculum development.

5. When respondents were asked about the advantages and disadvantages of their FLE program, they answered as follows:

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[1] Family Life Education administrative policy, N.J.A.C. 6:29-7.1, adopted by the NJ. State Board of Education in 1980.

[2] As we go to press, the State Department of Education (DOE) has issued a report on the implementation of FLE (NJ State Department of Education, 1986). While the study has the advantage of a large sample, all information was obtained from a survey mailed to County Superintendents who self selected data from among material already on hand to forward to the DOE. Thus, all local districts were not covered. The differences in source of information between the DOE undertaking and ours may account for any discrepancies in findings between the two studies.

TABLE 1: ADVANTAGES AND DISADVANTAGES OF THE FAMILY LIFE EDUCATION PROGRAMS, BY FLE RESPONDENTS

ADVANTAGES	NO. REPORTING	DISADVANTAGES	NO. REPORTING
Parental Acceptance	8	Too Few Hours	9
Community Acceptance	8	Lack of Funds	7
Giving Information to Students	7	Insufficient Teacher Training	6
Comprehensiveness of Course	6		
Students' Enthusiasm for Course	5		

N=14

Over half of the respondents cited acceptance by parents and the community as advantages of their programs. These findings in current parental and community acceptance are similar to past experiences such as the Eagleton Poll of August, 1980, which showed that 87% of parents of public-school children favored a sex education program and the NJ Catholic Conference's support of the sex education initiative.

On the other hand, less than half of the respondents felt that their courses were comprehensive while only about a third felt that students were enthusiastic about the subject. Over 60% felt that they had too few hours in which to teach the subject, half felt that they had too few funds but less than half cited the lack of teacher training as a disadvantage.

6. When asked to identify two priorities should funding become available, nine or over half mentioned teacher training, five mentioned additional resources such as arranging for outside speakers or purchasing audio-visual equipment and four suggested hiring new teachers.

7. Regarding current evaluation practices, only two of 14 stated that they evaluated the program, relying on informal student discussion or supervisory feedback.

8. Suggestions of possible evaluation practices were made by over half of the respondents as follows: Eight felt that pre-post knowledge tests, student assessments and analysis of pertinent pregnancy, abortion and birth rates were feasible approaches to the evaluation of FLE programs.

RECOMMENDATIONS

1. That schools which do not presently incorporate contraceptive education in grades 7 through 12 seriously re-evaluate their policies and make every effort to include the subject.

This recommendation follows from the research cited at the beginning of the chapter, in which education that is intensive and specific in discussing values clarification and contraception information proved most successful in decreasing pregnancies and sexual activity.

Since there is a student exclusion policy already in effect, students can be excused from particular sessions if they or their parents seriously object. Because it is our belief that the benefits of such knowledge far outweigh the negatives, school boards are strongly encouraged to include the subject of contraception unless overwhelming community objection is encountered. In point of fact, the DOE estimates that less than 1% of the parents of public-school children have chosen to have their children excluded from portions of the course. It is also our recommendation that along with the subject of contraception, others - such as responsible decision making, the right to say "no," the norms of acceptable societal behavior, future life roles and the effects of single parenthood - be discussed. In other words, a holistic approach is recommended.

2. That opportunities for teacher training be expanded.

FLE teachers should be financially supported so that they can upgrade their skills in course work at institutions of higher learning. Courses in human sexuality, child and adolescent development, family dynamics, etc., are offered by these institutions at times that suit teachers and usually at moderate costs. Additionally, the State Health Department, which has been a primary training resource through its Division of Family Planning and local Title X family planning providers, should receive specific funding so that it can expand training opportunities for school staff, perhaps conducted on a county or regional basis.

These recommendations are made because of the lack of a common knowledge base, the absence of requirements for skill enhancement as well as the finding in this study that few of the teachers could point to student enthusiasm in their classes. Additional training would go far toward improving these deficits, and rewards for completing course work would encourage teachers to make use of these opportunities.

3. That there eventually be certification of FLE teachers.

This would have the advantage of ensuring that those who teach the subject have a sound and common knowledge base and share basic teaching approaches. The development of a certification process would require collaboration between the Department of Education and the Department of Higher Education. In the case of FLE instruction in elementary schools, since the subject is often incorporated into the regular curriculum and taught by the classroom teacher, we suggest that a) a minimum of six credits of FLE course work be required; b) certification requirements be an integral part of the training given to aspiring elementary school teachers, and c) courses leading to certification be offered to all those presently teaching the lower grades.

In many schools, school nurses do the FLE teaching. Unfortunately, this tends to reinforce the perception that FLE is peripheral to the core program and is mainly a "medical" subject rather than one related to everyday life. Incorporating other school personnel would impress

students with the importance of the subject; also, classroom teachers should have requisite skills since they should be able to skillfully handle questions from students that may surface at any time of the day, not only during FLE sessions.

4. That FLE programs be routinely evaluated by teachers and/or supervisors.

Evaluation is necessary to improve the quality of instruction and maximize its effectiveness, to choose alternate teaching methods if some are found wanting and to encourage new ideas and approaches. Evaluation information should be made available to teachers, administrators, and school boards, and interested parties such as parents and students should have access upon request.

Mindful of the potential pitfalls of some types of evaluative approaches (Kirby, 1985), we suggest that student feedback and pre/post knowledge tests be used since the interpretations of results relate to the material being taught, and the findings can be used for program development. By contrast, we do not recommend the use of such methods as trend analyses of pregnancy, abortion and/or birth rates because these outcomes are greatly influenced by many factors (such as the availability of birth control, poverty, family cohesiveness) over which the programs have no control.

II. SCHOOL-COMMUNITY LINKAGES

OVERVIEW

Schools are where most children are, and therefore schools are the logical sites for preventive services geared to reach the general school-aged population. However, schools need not assume sole responsibility. Many New Jersey organizations have undertaken preventive education programs. Some are health-related, such as family planning clinics, and some have traditionally emphasized recreation and socialization activities such as the YM and YWCA's, Boys' and Girls' Clubs, Girl Scouts and Urban League. While a number of FLE programs currently make use of the expertise of these organizations, there could undoubtedly be greater emphasis on a school-community liaison with these groups that could make preventive efforts in the classroom more successful.

In other parts of the country, an innovative health-related movement is taking place that is linked to the schools but not to the FLE programs per se. Sited either in or near schools in a very conscious effort to reach students, health clinics have been developed that have proved to be very effective in reducing pregnancies in schools that have had very high rates. These school-based clinics are located in 32 communities around the nation. They are staffed by medical professionals employed not by the schools but by licensed medical facilities such as community hospitals with funding coming from outside sources rather than educational budgets. These clinics offer comprehensive health services to the students in the school from sports physicals to immunizations, from weight-reduction programs to post-partum care. Consequently, they meet health needs in underserved populations and, at the same time, give students referrals to outside family planning agencies without singling them out for special attention.

Another health-related program that could be of potential use in teaching and offering preventive services is the Early Periodic Screening, Diagnosis and Treatment Program (EPSDT) that is available to all children up to the age of 21 who are eligible for Medicaid. While this program would not be of help to the general school population, it could benefit schools with large numbers of students receiving Aid to Families with Dependent Children (AFDC) who are eligible for Medicaid. Briefly, EPSDT is the preventive portion of the Medicaid program, a joint federal-state funded medical program for the poor. EPSDT offers care that is not illness-related but preventive in nature, such as developmental assessments and vision and dental screenings, and can offer reproductive health care at the discretion of the physician. Unfortunately, only 11% of New Jersey's EPSDT-eligible children received the recommended annual health screening in 1985[1] and reproductive health care usually has not been stressed. However, school districts with large numbers of children who qualify for the program could begin to think of this as a way of underwriting the cost of school-based health care, particularly and/or including pregnancy prevention services.

FINDINGS ABOUT SCHOOL-COMMUNITY LINKAGES

Some of these findings were gathered during the interviews while others are the result of subsequent contacts.

1. Most of the FLE respondents indicated that they invite representatives from community agencies (primarily family planning clinics) to be guest speakers.

2. In one school district, a representative from a local substance abuse program is present at the high school at least one afternoon each week.

3. Also in that same district, an EPSDT program is conducted since more than half the enrolled children are eligible.

4. There were no school-based clinics in New Jersey at the time the study was conducted (Fall, 1985).[2]

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[1]This estimate is based on the number of eligible children in NJ (292,058 as of Dec., 1985) and the number of EPSDT screenings (33,125) that took place in that year. Note that this is considered a slight underestimate which assumes that EPSDT participants have early check-ups, does not consider a tendency to overcount Medicaid-eligible clients and disregards children's participation (about 700 state-wide) in an alternate and new Medicaid program, called the Personal Physician Plan.

[2]It was just learned that an RFP for school-based clinics in New Jersey school districts has been issued by a large medical foundation. If things progress satisfactorily, one or more such clinics should be in operation next year. Enabling state legislation may also beforthcoming.

RECOMMENDATIONS

1. That local school districts learn about and make greater use of already existing community programs, both public and private, in order to enhance the FLE programs and make appropriate services available to students.

   School personnel should be oriented to existing community resources and, in turn, the community/agency staffs should be introduced to the school, in order to increase referrals to existing resources such as health care, substance abuse, financial assistance and children's protective services. Guest speakers, audio-visual aids, printed materials from outside community agencies should be utilized to build curricula and reach students more effectively. Moreover, staff training should be undertaken with an eye toward taking advantage of the opportunities currently offered and potentially available from community agencies. Private and public agency personnel should visit schools on regular schedules for the purposes of referral, educational programming and/or direct medical and intervention services.

   The State Departments of Health (DOH), Human Services (DHS) and Education (DOE) should establish cooperative agreements to provide technical assistance to facilitate these linkages of schools and community services. This is related to the recommendation of a state lead agency (see Executive Summary and concluding section).

2. That EPSDT services be brought into school districts that have substantial AFDC/Medicaid populations and be restructured so as to include reproductive health services for adolescents.

   All concerned state departments should join in collaborative efforts to establish these screenings in affected schools. Specifically, current efforts to increase the EPSDT program, whether on the county or state level, should be widened to include a push to enroll adolescents and to include reproductive health in the services being offered. In order to add physicians willing to work with this program, there should be an effort to a) increase the reimbursement rates for these services and b) modify federal regulations so that Nurse Practitioners could receive similar reimbursements, thereby increasing the supply of practitioners available to conduct screenings.

3. That the State of New Jersey explore the feasibility of developing school-based health clinics within specific schools and/or school districts.

   As indicated in the footnote, foundation support will probably be available next year for at least one such clinic. However, the DOH, DOE and DHS should explore the possibilities of funding additional clinics to be established in junior and senior high schools around the state according to need. Medicaid support paying for services rendered would be available in areas with large numbers of eligible students. Experience in other states has shown that, while foundation support has been essential for "start up" costs, the financial burden is later shifted to regular channels.

III. THE ROLE OF FAMILY PLANNING WITHIN COUNTY WELFARE SERVICES

Family planning services, while easily accessible to the middle- and upper-income woman, is hard for the poor to come by. The estimate in 1984 was that only about 25% of the state's women at or below 150% of the poverty level who needed family planning services had access to free or subsidized services. Similarly, only about 28% of the teens at risk of pregnancy had similar access (Family Planning Advocates of New Jersey, 1986).

Statistics of this nature describe a situation sadly lacking in fairness and equity. Those women better able to shoulder the financial burdens of child rearing are the very ones for whom contraceptraception is easily available, making it possible for them to delay or refrain from child bearing. A more humane and logical system based on need would reallocate services. This would make them accessible to the population unable to afford not only the family planning services themselves but also the medical care and the long-term financial as well as emotional committment of raising a family.

The most equitable as well as the least difficult way to reallocate services would be to ensure that programs already in place that provide for needy women of child-bearing age include family planning among their array of services. In fact, family planning should be strongly emphasized as a method of enabling a woman to control her fertility, to improve her life chances and to take advantage of widened horizons - in short, to have the same opportunities presently available to her more affluent neighbor.

Prioritizing this suggestion - helpful in these days of state and federal budget constraints - translates into making family planning accessible in the program serving the most needy women and adolescents - the AFDC program. In New Jersey, this population lives on a yearly income level of only about half the official poverty line, certainly qualifying recipients as being the largest group of needy women of child-bearing age.

How then to incorporate enhanced family planning services into the AFDC program? Perhaps the most easily instituted method would be to make information available at a place that AFDC families visit periodically - at semi-annual conferences with welfare workers, called to recertify eligibility for the program. Such information could be provided in a variety of ways - see the following section on recommendations. Note that this issue has been explored because of its potential to easily reach large numbers of low-income women of child-bearing age and provide them with the types of services that are readily available to those with greater means. It goes without saying that any of these efforts at the time of recertification must be done with tact and sensitivity. Great pains must be taken so that the client never feels that the use of contraception is held as a threat to continuation in the program. Moreover, family planning should be thought of as more than a mechanistic, device-oriented method of controlling fertility. It should be part of a larger agenda including such items as self esteem, life planning, career expectations and aspirations.

Because we were interested in the possibilities of this approach, we directed questions pertaining to current practices around family planning discussions to the CWA respondents during the interview.

FINDINGS

1. All CWA respondents were asked how often they discussed family planning with clients coming to their offices for semi-annual AFDC recertifications. Table 2 below, shows their responses:

   a. County Welfare Agencies do not have consistent practices regarding such discussions with AFDC heads of households.

   b. Very little discussion of family planning is done with the teen parents who are on their mothers' grant or with their younger siblings, a group that research has indicated to be at high risk (Guttmacher, '81; Dreyfoos, '83 and Moore, '78).

   c. If talks are held with anyone, it is with the household head.

TABLE 2: FREQUENCY OF DISCUSSING FAMILY PLANNING WITH AFDC CLIENTS AT RECERTIFICATION, BY COUNTY WELFARE AGENCY RESPONDENTS

TYPE OF AFDC CLIENT	FREQUENCY				
	ALMOST ALWAYS	FREQUENTLY	OCCASIONALLY	RARELY NEVER/DK	TOTAL
Heads of Households	6	3	3	9	21
All Adolescents	4	3	2	12	21
Siblings of Adolescent Parents	1	2	4	14	21

2. Respondents were asked what their office could do to strengthen preventive efforts for teen pregnancy. Four mentioned increased outreach and two others pointed to a more aggressive strategy by their office's Family Planning Unit. Fifteen did not answer.

3. Respondents were also asked whether specific entitlement programs could be strengthened. Eight of the 21 respondents felt that EPSDT services might play a bigger role in teen pregnancy prevention. In addition, ten respondents said yes when asked specifically if Family Planning Units could play a stronger role.

   It should be noted that the workers' lack of consistency in discussing family planning, shown in Table 2, may reflect the realization that family planning is just not readily accessible to this clientele. In addition, several CWA respondents indicated that private physicians were unwilling to provide obstetrical/gynecological services to Medicaid patients, a situation especially critical in rural counties where subsidized medical clinic services are non-existent. Thus, any efforts to counsel, discuss or disseminate information about family planning to AFDC clients must deal first with making reproductive health care more widely available to all poor women.

RECOMMENDATIONS

1. That funding for family planning services be increased.

   As stated earlier, it is futile to talk about ways of encouraging sexually active teens to use contraception unless low-cost services are available. Therefore, making low-cost family planning services available to all women in need is a necessary first step. Efforts should include a) additional state and private subsidies to agencies and clinics so that they can expand these services; b) an increase of Medicaid fees so that more physicians will serve needy women and also to fully cover the costs of Family Planning Clinic Services so that their other funding sources are not being used to subsidize the Medicaid program; c) a move to institute school-based clinics that would help educate poor adolescents and refer them to services, and d) expansion of EPSDT programs to include family planning.

2. That ways of encouraging AFDC clients to use family planning be explored.

   Improved data collection by the Division of Public Welfare could facilitate the targeting of high-risk families for specific prevention strategies. In this regard, it is worth noting that the two organizations sponsoring this report have studied the DPW Management Information System and have suggested ways in which existing resources could be used to identify adolescent parents. With this information, a variety of strategies could be directed specifically at teen parents and their younger siblings. Educational programs could be arranged; waiting-room time could be used for counseling or information sessions; increased outreach could be instituted; informational packets could be given and referral processes to family planning agencies could be strengthened. As mentioned before, care should be taken so that this is not perceived as a threat to continuation on AFDC.[1]

IV. HIGH-RISK ADOLESCENTS AND FAMILY PLANNING IN SUMMER YOUTH EMPLOYMENT PROGRAMS

OVERVIEW

This section emerges not from study findings but from an informal review of innovative programs. In the Summer Training and Education Program (STEP), a pilot summer-jobs program operated in five cities by Public/ Private Ventures in Philadelphia, PA, a specialized curriculum was devised to address what were seen as two primary causes for dropping out of school: poor academic performance and teenage pregnancy (Public/Private Ventures, n.d.). The curriculum included a life planning component stressing responsible sexual behavior and remedial reading/math skills.

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[1] As we go to press, the DPW has just awarded special grants to three CWA's, allowing priority targeting of special services to teen parents.

RECOMMENDATION

That a preventive approach be incorporated into the summer youth employment programs funded by the Jobs Partnership Training Act (JPTA).

Components of the FLE programs in the public schools should be included in the summer youth employment programs. In addition, the curriculum could be modeled after the STEP program in an effort to prevent premature school leaving. In fact, if a cooperative relationship could be established between the Division of Public Welfare, the Department of Labor and the State Department of Health's Family Planning Division, outreach efforts and referral procedures could be strengthened. In addition, staff of the welfare agencies and JPTA programs could profit from training in the issues of sexuality, adolescent development and family planning.

TREATMENT SERVICES: FINDINGS AND RECOMMENDATIONS

The previous section discussed prevention programs and services; this section details findings about treatment services, i.e., services to those teens who are pregnant and/or parenting.

It will be recalled that the majority of our respondents were involved in treatment - 26 of the 46 community agencies, 21 county welfare agencies, 20 DYFS offices and 10 school programs for pregnant teens.[1] The 26 community agencies worked with adolescents who were pregnant and parenting and included special hospital-based programs and social service agencies. As already indicated, findings about operational characteristics, whether they be of preventive services or treatment services, are reported in this section in order to avoid duplication.

A word about operational characteristics: The purpose of this survey of over 100 service providers working in the area of adolescent pregnancy was to examine the way in which four aspects of their programs were being handled. These four that can be termed operational characteristics are a) linkages to other services, b) accessibility of the programs, e) training offered to staff, and d) the practices of evaluation being carried out. The first letters of these four items form the acronym LATE, an apt description of services that must make the best of a situation that should never have occurred.

I. LINKAGES

OVERVIEW

It is generally recognized that very few if any agencies can provide the entire gamut of services that clients may need. Consequently, linkages in the form of referrals to other resources must be developed so that these missing elements may be provided. In addition, verification that the referral has been acted upon and that the services have been provided is also needed, as emphasized by the United Way in its standards for information and referral services (United Way, 1980). This need for verification becomes increasingly imperative in work with an adolescent population. From what we know about teen behavior, that teens have difficulty seeking services in the first place, one can safely assume that adolescents have similar difficulties with a referral. This underscores the necessity to monitor after the referral is made to see that it is indeed acted upon.

For the purposes of this survey, we looked at the two following indicators of linkage: referral practices and the degree of joint programming/collaboration. In the area of referral practices of agencies, the two issues examined were the frequency with which clients were referred to 15 specific services[1] and the extent to which receipt of these services was verified. These characteristics of the referral process were chosen because frequency indicated the degree to which linkages were being initiated, and verification suggested the degree of commitment being made to

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[1]Of the community agencies, the 20 that provided preventive services were primarily family planning agencies.

ensure that the services were actually received. In addition, respondents were asked to describe any problems that they had experienced in the area of referrals. As for joint planning and programming, our interest stems from our experience that agencies cannot be expected to provide all services and therefore a committment to satisfy unmet need leads inevitably to efforts to collaborate and plan with others.

FINDINGS ABOUT LINKAGES

A. REFERRALS AND VERIFICATION

1. Almost one-third of the respondents reported that few referrals were made and/or that they were not aware of their agencies' practices about verification.

2. According to respondents, most agencies did not consistently verify that clients had received the services to which they had been referred. Only 14 of 87 agencies (about 15%) routinely did so.

3. Another 22 respondents (about a quarter) reported that they generally verified as needed. (How well they carried this out depended on their criteria for choosing cases needing verification.)

These findings are shown in the table on the next page.

Although our survey did not ask respondents why they had not made referrals, other information suggests at least one pertinent factor: As will be seen in the forthcoming section dealing with procedures at intake, very few of the community agencies asked questions at the initial information session beyond what was of immediate interest to their service. Thus, data about topics such as physical health, living arrangement, relationship with baby's father or school enrollment were very often unknown, and therefore the agency was not in a position to make knowledgeable referrals.

On the other hand, the finding that about two-thirds of the agencies did indeed make referrals and that 14 respondents routinely verified them indicates that a) referrals can be made where the commitment to do so exists and b) that follow-up is a feasible activity. The fact that public agencies (CWA's and DYFS Offices) reported higher percentages of routine follow-up may be explained by the fact that they frequently need to verify receipt of services for billing purposes.

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[1] See the types of services listed below Table 3 on the following page.

TABLE 3: COMPARISON OF REFERRAL PRACTICES FOR COMMUNITY AGENCIES, CWA'S AND DYFS OFFICES

REFERRAL PRACTICE	COMMUNITY AGENCIES	CWA	DYFS	TOTAL
Referred for at least 10 of 15 services[a] and routine verification that client received service	3	8	3	14 (16%)
Referred for at least 10 of 15 services and generally verified as needed	15	3	5	23 (26%)
Referred for at least 10 of 15 services and generally no verification	12	5	6	23 (26%)
Respondent not aware of whether referrals were verified and/or reported that referrals to 15 services were generally not made	16	5	6	27 (31%)
TOTAL	46(53%)	21(24%)	20(23%)	87(100%)

N=87

[a]Services included abortion, adoption, child care, contraception, counseling, education, financial assistance, food stamps, foster care, parenting classes, pediatrics, prenatal care, pregnancy testing, residential, vocational training and WIC.

B. REFERRAL PROBLEMS

When respondents were asked about problems they perceived regarding their referrals, they answered as follows:

1. About half reported that clients did not follow through. This was the problem most often cited. In many cases, respondents stated that it was necessary to make persistent contacts in order to ensure that the appropriate appointment was made.

2. Almost one-third of the respondents reported that there were problems with the accepting agency - that they had put the client on a waiting list or had been unable to provide the service.

3. IN ALL THREE SITUATIONS, AGENCIES WITH RIGOROUS FOLLOW-UP PRACTICES REPORTED FEWEST DIFFICULTIES.

These findings are shown in the table on the following page. (Note that a respondent could choose one or more responses.)

TABLE 4: RESPONDENTS[1] PERCEPTION OF REFERRAL PROBLEMS BY THEIR REFERRAL PRACTICE

PROBLEM REPORTED (In Rank Order)	RESPONDENT'S REFERRAL PRACTICE[2] MANY REFERRALS/ ROUTINE FOLLOW-UP	MANY REFERRALS/ FOLLOW-UP AS NEEDED	FEW REFERRALS/ INFREQUENT FOLLOW-UP	TOTAL
Clients Did Not Follow Through	7	13	18	38(36.5%)
Clients Put on Waiting List	4	8	14	26(25%)
Agency Did Not Provide Service	3	12	14	29(28%)
MD Fees Too High	1	1	9	11(10.5%)
TOTAL	15(14%)	34(33%)	55(53%)	104(100%)

[1]There were 87 respondents responsible for referral: 46 community agencies, 21 CWA's and 20 DYFS offices. Each respondent could list one or more of these four problems and 104 problems were identified.
[2]The respondents' referral practices were classified as per Table 3.

The finding that adolescents are frequently unable to follow through with referrals reinforces our previous statement that intensive outreach and aggressive monitoring of referrals is an absolute necessity when working with teens. Clearly, these are critical components of case management for adolescents.

Note that when we asked about difficulties with referrals we were inquiring about EXISTING services and obstacles encountered in obtaining them. The findings indicated in Table 4 do not reflect gaps in services or areas of unmet need. A later section will deal with that issue.

C. COLLABORATION (JOINT PLANNING/PROGRAMMING)

As indicated in Table 5 below, community agencies engaged in collaborative efforts more often than public agencies. Most often their partners were other voluntary agencies and, to a lesser extent, the schools. According to our analysis, CWA's and DYFS infrequently engaged in joint planning and/or programming. (Note that, in giving a response, a respondent could choose more than one type of agency.)

TABLE 5: COLLABORATION WITH OTHERS FOR JOINT PLANNING/PROGRAMMING

RESPONDENT[1]	AGENCIES WITH WHOM COLLABORATION WAS CARRIED OUT				
	COMMUNITY AGENCY	SCHOOLS	DYFS	CWA	TOTAL
Community Agency	38	37	23	19	117 (73%)
DYFS	13	15	-	a	28 (18%)
CWA	9	6	a	-	15 (9%)
TOTAL	60(38%)	58(36%)	23(14%)	19(12%)	160(100%)

[1]There were 46 community agencies, 21 CWA's, 20 DYFS offices.
[a]Not asked.

RECOMMENDATIONS

1. That referral practices be enhanced in all agencies, and verification that services are being or have been given should become as an integral part of the process.

   Agencies, both public and private, should expand their referral practices to send clients to services beyond their specialization. Only by viewing the client in the totality of his or her needs can the worker be effective. Thus, a comprehensive intake form is mandatory[1] and workers need to become aware of community resources to which clients may be referred. To that end, time and training must be devoted.

   Most importantly, agencies should be expected to routinely verify whether clients receive the services to which they are referred. This is especially needed whom working with an adolescent population. Teen behavior patterns are such that youth are loath to ask for service and, having been referred, procrastinate in either making or keeping an appointment. If providers insist that routine follow-up is not feasible, they should incorporate a policy of conducting verification on an as-needed basis, developing criteria by which cases needing mandatory verification can be identified. Referral practices should be monitored, and priority for funding should be given to those agencies that have a follow-up policy.

2. That inter-agency collaboration (joint programming/planning) be encouraged among the various state departments directly involved, i.e., Education, Health, Human Services, Labor, Women, Corrections and Higher Education.

   Our data indicate that collaboration, which appears to exist among community agencies, is very little in evidence among public bodies. And yet, joint planning is necessary if adolescent pregnancies are to be

[1]See Section II, D, Pg. 28

reduced. Therefore, every effort must be made to encourage the collaboration of the above departments, both among themselves and between each of them and community agencies and/or schools.[1]

For example, if school dropouts are being worked with, the Department of Education could collaborate with the school and social agency to encourage and facilitate re-entry. The collaboration could be system-wide, could be targeted to at-risk populations, neighborhoods or schools or could be started as a pilot demonstration project. In order to forge a link between public and private bodies, technical assistance and joint training should be provided as well as co-sponsored seminars and problem-solving sessions. To stimulate such collaboration, the various departments could develop affiliation agreements, spelling out methods and standards. (The DYFS agency contract could serve as a model.)

Note that this recommendation is related to another having to do with collaboration and joint planning which is discussed in the Executive Summary and concluding section.

II. ACCESSIBILITY OF SERVICES

OVERVIEW

For the purposes of our survey, accessibility was broadly defined to include both items generally recognized as making up that category and items often thought of as program components. Our rationale for including the latter under the rubric "accessibility" lies in the fact that they either facilitate reaching out to family members, thus making service accessible to them as well as to the client, and/or they bring skills of various sorts to the teenager, thus making them accessible to her or her.

Thus, accessibility was defined in the traditional sense to include hours of opening, transportation and outreach. In the non-traditional sense, intake practices were included, since the initial needs assessment strongly influences whether needed services will be made available. (This was discussed briefly in the Linkage section.) Also included among these items is the provision of critical services such as supports to family members and teen fathers, comprehensive parenting education, vocational training and services related to the AFDC program.

A. HOURS OF OPENING

FINDINGS

1. Of the 46 community agencies, half were open only during business hours although 8 of these had emergency coverage - frequently a hot line used for referral. Half were open at other times as well, the largest portion - 19 agencies or 41% - having evening hours during the week while four (9%) had some weekend hours.

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[1] As we go to press, a "State Agencies Network," involving all the above departments, is meeting to address the issue of adolescent pregnancy.

2. In contrast, the DYFS and CWA offices were open only during business hours.

3. Not surprisingly, all 34 school programs were open only during school hours, although one program for pregnant teens scheduled occasional weekend activities.

These findings emphasize the difficulties faced by pregnant or parenting teens who must make routine doctor and agency appointments while at the same time they are expected to continue to attend classes regularly. The unavailability of services at times other than the school day, making it necessary to skip classes, sends a message that downplays the importance of school attendance.

It might be argued that the students could take care of their business at the end of the school day, thus eliminating the need to cut class. However, a number of problems are present: agencies cannot accommodate all teens wishing to be served in these limited hours, other clients also claim attention at that time, and agencies cannot handle the increased client load.

RECOMMENDATIONS

That public and community agencies institute evening and/or weekend hours or, if impossible, send workers regularly into the schools to offer services.

DYFS and CWA's should explore the feasibility of instituting expanded hours, perhaps on a flex-time basis. If civil service regulations and/or union contracts make this impractical, the agencies could set up outposts in the schools themselves, in particular covering those containing large numbers of students needing services.

Because community agencies do not have the same union and civil service constraints as public agencies, it is anticipated that hours could easily be extended into evenings and/or weekends as presently done in community mental health centers. This could be one of the criteria taken into account by funding agencies when they examine the ability of the agency to meet community need.

Again, where this extension of hours is not feasible, staff should routinely visit the schools to serve clients in order to reinforce the message that class attendance is of the highest priority. The students would be able to take advantage of free periods during the day and/or the few hours at the end of school if arrangements could be made to keep the necessary room(s) open. By offering services where the students are, the tendency of teens to put off appointments and the seeking of help would be alleviated and the importance of uninterrupted schooling would be reinforced.

B. TRANSPORTATION

OVERVIEW

In New Jersey, an individual must be at least 17 years of age in order to qualify for a driver's license. In families without a car, where no older driver is present, in areas with little or no public transportation, and particularly in rural areas where services are miles apart, this is a great deterrent to getting needed services. It is no wonder that those working in the field of adolescent pregnancy recognize that the lack of transportation is one of the major gaps in services to this population.

FINDINGS ABOUT TRANSPORTATION

1. The majority of the community agencies did not provide transportation. Twenty-nine or 67% of the community agencies provided no type of transportation whatsoever. Eight (about 20%) operated vans or buses and transported all clients to the service, and six others helped selectively, providing transportation and/or reimbursement to some clients.[1]

2. DYFS and CWA's provided carfare in some circumstances if there was a request from the client.

3. Seven of the ten educational programs for pregnant teens provided transportation for everyone and one program reimbursed all students for travel.

It is worth noting that one vocational program, recognizing that the driver could play an important outreach function, hired a driver with a college background who served as both a role model and outreach worker, skillful at motivating student attendance. Such adjunct staff in unofficial capacities may be very helpful in stimulating and inspiring adolescents.

RECOMMENDATIONS

That transportation be viewed as an important element of service delivery. That programs operate some form of transportation for teen clients when none is available or customarily pay carfare when public routes exist.

Transportation should no longer be a peripheral issue. It is a very practical problem that greatly impedes this population's receipt of needed services. Transportation would not only enable clients to attend and do so regularly, but could also provide additional workers in the form of drivers who could be trained in valuable outreach techniques.

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[1]Only 43 community agencies were included in this question since three were residential agencies where transportation was not an issue.

C. OUTREACH

FINDINGS:

Two-thirds of the 46 community agencies surveyed (31 agencies) did not assign any staff to outreach functions. Of the third who did incorporate outreach, most used part-time staff.

This lack of outreach is surprising since most of the agencies employed social workers and/or health educators, disciplines that are schooled in the techniques of and the rationale for outreach. Moreover, the agencies were familiar with adolescents and their characteristic reluctance to seek help, a characteristic that calls for an aggressive outreach effort.

RECOMMENDATIONS

1. That outreach efforts be routinely incorporated into the various programs serving pregnant and parenting teens.

   Research has demonstrated that adolescents are often reluctant to seek services (Lee, 1984). Moreover, even when they come for aid, they are often intimidated by established agency procedures and may not persevere unless encouraged. Aggressive outreach can overcome the barriers and ensure that teens receive help. Without such efforts, many will remain unserved.

2. That attention, support and encouragement be provided to part time outreach staff to counter feelings of isolation from their colleagues and burnout from job difficulties.

   The practice of hiring part-timers, while perhaps cost effective, has drawbacks in that the worker is often unable to meet regularly with other staff members. Without feeling a part of a cohesive staff, the worker may have difficulty in countering the frustrations found in the field. Agencies should provide opportunities for professional socializing, joint training, and obtaining job benefits, and offer help in defining realistic expectations.

D. INTAKE PRACTICES

FINDINGS

To find out about intake practices, agencies and schools offering treatment services[1] were asked whether a standardized list of questions was used by agency personnel when new clients were being interviewed. This would insure a uniformity in the data that was collected even though workers themselves might change. Over 75% of the 56 respondents reported that they had a standardized intake form, and no difference was found between community agencies and schools in this regard.

When agencies were asked to describe the types of questions asked during intake, the following information was obtained:

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[1]These were 56 community agencies and school programs for pregnant teens.

1. Only about one-fifth of the providers of treatment services made use of what is generally considered a comprehensive intake, one that asked about 1) living arrangements, 2)involvement with other agencies, 3) family relationships, 4) physical health and 5) the client's relationship with the baby's father.

2. Most often asked at intake were questions about living arrangement; next, involvement with other agencies. Least often asked were questions about family relationships and physical health. Half of the agencies offering treatment services asked about the relationship with the baby's father.

This information is contained below:

TABLE 6: INFORMATION COLLECTED AT INTAKE BY COMMUNITY AGENCIES AND SCHOOL PROGRAMS FOR PREGNANT TEENS

KINDS OF INFORMATION	COLLECTED AT INTAKE		
	YES	NO[a]	TOTAL
Living Arrangements	34 (60%)	22 (40%)	56 (100%)
Involvement With Other Agencies	30 (54%)	26 (46%)	56 (100%)
Family Relationships	26 (46%)	30 (54%)	56 (100%)
Physical Health	26 (46%)	30 (54%)	56 (100%)
Relationship with Baby's Father[b]	18 (50%)	18 (50%)	36 (100%)
All of the Above[c]	10 (18%)	46 (82%)	56 (100%)

[a] Includes two "Don't Know" responses
[b] The 20 agencies offering primary prevention were excluded
[c] The 20 agencies offering primary prevention are listed if they collected the first four items of information.

Findings such as these, showing a frequent incompleteness in the data gathered at the initial interview, raises questions about the ability of providers to serve their clients. If a comprehensive assessment is not taken, the service plan that is developed - while it may offer the services in which the agency specializes - will not be optimally effective. The full extent of the specific need will go uncovered, and the agency will not be able to make the appropriate linkages that might well provide what is required.

RECOMMENDATION

That a comprehensive intake be used by all service providers.

This will enable an appropriate service plan to be developed, thereby enhancing the ability of the agency to help the pregnant or parenting teen. Agencies should monitor their intake practices to ensure the

uniformity and adequacy of data gathered. Additionally, we suggest that the subject of substance abuse be added to the list of items included in the intake form, since such information is critical to working with this client group.

E. SUPPORTS TO THE TEEN MOTHER'S FAMILY AND THE BABY'S FATHER

OVERVIEW

The extent to which service providers worked with members of the teen's family was included in our survey since family is so often involved in important issues such as whether to continue schooling, methods of and ability to parent the infant, and the way in which new responsibilities are handled.

The extent of agency involvement with the infant's father was also part of our interviewing. We all know that the traditional societal and parental response has been anger, blame and a withdrawal of interest and support. However, a new body of research indicates that positive results can emerge from engagement of the teen father. A report just released evaluates demonstration projects in eight major U.S. cities that included the fathers among those served (Klinman, Sander, et al., 1985). One of the most significant findings is "that many, many of these young men want to, and have the capacity to support their children. They help out in many ways, emotionally, financially, psychologically, concretely."[1] This research, representative of other such attempts at enlisting the fathers, is convincing workers and agencies to expand services to the previously forgotten young man.

In looking at services we recognized that it may sometimes be prudent for the young mother to distance herself from her family and/or the baby's father. One prime example is reproductive health services. Agencies offering such service often consider it inadvisable to involve the parents of their adolescent patients. Because of this, the responses from all 20 community agencies providing primary prevention were excluded from this analysis since they all offered family planning.

Service providers who dealt with families and fathers had a number of ways of contacting them, ranging from simply including them in special events, such as a Mothers or Fathers Day Party, to having them regularly participate in counseling or group sessions.

FINDINGS

For the purposes of this study, we considered whether or not the teen mother's family or the infant's father were involved in agency activity and if so, the type of this activity. As indicated above, agencies offering family planning were excluded. The results are contained in the following table:

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[1]Quoted from "Male Teenagers Confront Paternal Roles," NASW News, June, 1986.

TABLE 7: REPORTS OF INVOLVEMENT OF TEEN'S FAMILY AND INFANT'S FATHER IN SERVICES PROVIDED BY AGENCIES[a]

RELATIONSHIP	TYPE OF ACTIVITY	DEGREE OF PARTICIPATION				
		NONE	FEW (LESS THAN 25%)	SOME (26%-50%)	MANY/MOST (MORE THAN 50%)	TOTAL
Mother's Family	Special Events[b]	15(42%)	19(52%)	1(3%)	1(3%)	36(100%)
	Ongoing[c]	16(44%)	7(19%)	3(8%)	10(28%)	36(100%)
Infant's Father	Special Events[b]	15(42%)	14(39%)	3(8%)	4(11%)	36(100%)
	Ongoing[c]	13(36%)	19(52%)	4(11%)	0	36(100%)

[a]Agencies reporting: 26 Community agencies providing treatment services and 10 school programs for pregnant teens.
[b]Open houses, holiday parties, graduations.
[c]Regular attendance at counseling sessions or classes.

1. As can be seen above, less than one-third of the service providers engaged the families either in special events or on an on-going basis. As for the father, even fewer agencies - about a tenth - included him, and then only in special events.

2. Half of the 36 respondents stated that it was not feasible to involve either families or fathers even if additional resources were available. Several stated that the mother's family and infant's father were too problematic, and involving them would be counterproductive.

It is our position that this point of view should be reconsidered. While it may sometimes be correct, it is not invariably so. Consider: A body of research shows that adolescent mothers who remain with their families fare better in terms of schooling and employment than those without such support (McGee, 1982; Miller, 1983; Barrero, 1984). With this in mind it may well behoove programs to set up opportunities for positive interaction between the adolescent mother and her family, thereby increasing the chances of building and maintaining family supports.

In the same vein, while there may be valid reasons for excluding the father, the worker should be certain that the causes are serious enough for such rejection. Several good reasons exist for including him. The value to the child is inestimable; having a sound relationship with both parents is generally recognized as beneficial for sound growth and development (Wallerstein, 1980). Recent research by a number of social scientists indicates that adolescent fathers can take an active and beneficial role in parenting (Klinman, 1985; Ballard, 1984; Sullivan, 1985). And finally, the attitude and support of the male partner has been found to be a major factor in the consistent use of effective contraception by the young woman (Akpom, 1976). This is especially important since the overall goal is to avoid further pregnancies.

RECOMMENDATIONS

1. That programs attempt to involve the extended families of the adolescent clients, excluding them only when clearly inappropriate.

   The above research, showing family support correlated with better school and employment outcomes for the teens, should be ample incentive for attempts at helping families stay together. Even with limited resources, occasional involvement in the form of open houses and holiday parties can be arranged. In order to maximize participation at these events and to encourage more ambitious initiatives such as group sessions, funding agencies might consider providing technical and/or financial assistance.

2. That attempts to reach out to and serve the adolescent father be instituted whenever possible.

   The research cited above, giving evidence of positive results to the child and young mother from interaction with the teen father, should prod service providers into innovative programming. While not all fathers would be appropriate, it is worth making the effort to find cooperative males for it helps build a foundation of support and caring that will enable the young family members to face the future more successfully. At a minimum, programs could have monthly Fathers Days, giving recognition and support to young fathers.

   One impediment to involving adolescent fathers is the commonly-held definition of fatherhood that equates that status with financial support. Federal and state initiatives to insure child support from absent fathers are examples of this. And indeed, we feel that fathers should be held financially liable for their children. Unfortunately, most teen fathers are unable to assume the financial responsibilities of a young family. Holding them responsible for financial support that they are unable to give reinforces any feelings of failure that may already be present. Thus, it is our contention that services developed for adolescent fathers should a) emphasize the importance of parenting in order to give emotional support to the young family; b) give vocational training to maximize the chances of employability; and c) offer career planning that may lead the young men and, if they remain a unit, the young family to eventual independence. An enhancement, rather than a diminishing, of self esteem is required. Even if the teen father does not remain with the young woman and child, he will have skills to enable him to become a contributing member of society able to care for his family in the future.

F. PARENTING EDUCATION

OVERVIEW

Professionals working in both the fields of health and child development often cite the need for increased parent education. Nurses and doctors repeatedly complain of parents who are unable to distinguish early signs of illness or to practice good hygiene and nutrition. Those who work in the area of child development are often dismayed by the parent with

completely inappropriate expectations of the infant or child given its developmental stage or who do not communicate with, or offer stimulation to their offspring. For parents like these, of whom inexperienced teens form a large percentage, parenting classes are extremely important.

FINDINGS

Included in our survey was a question asking whether the agency offered parenting education to their adolescent clients. Over half of the community agencies that were interviewed (25 of the 46) indicated that they did indeed offer parenting education, but only half had a written curriculum.

In order to assess the comprehensiveness of the course content, copies of the written curricula were reviewed. From those lacking a written curriculum, lists of topics were obtained. Below is a table indicating the extent to which a wide range of topics were incorporated:

TABLE 8: TOPICS ADDRESSED IN PARENTING EDUCATION, BY RESPONDENTS FROM COMMUNITY AGENCIES

TOPIC (In Rank Order)	YES	NO
Nutrition	25	0
Child Development	22	3
Relationship with Families	22	3
Labor and Delivery[a]	21	4
Relationship with Babies' Fathers	21	4
Providing for Child Care	19	6
Family Planning	19	6

N=25

[a]Even if teens have delivered, it has been found that they may not have a clear understanding of the birth process.

1. Almost 80% of the respondents covered several critical topics in their parenting classes. Whereas nutrition tops the list - taught by all agencies having parenting classes - topics least often covered were providing for child care and family planning.

2. Note again that half of the agencies offering parenting education did not have a written curriculum. This raises the distinct possibility that the training is not consistent from class to class, relying too heavily on the skills and commitment of individual trainers.

RECOMMENDATIONS

1. That the agencies presently lacking parenting classes re-evaluate their programs with an eye toward adding this service if it is compatible with agency mandate.

   Agencies working in the field could develop parenting classes, often without additional investment in personnel, while facilities such as infant and day care centers or group housing arrangements could incorporate such classes into their own settings. Teaching would not have to be didactic but could be in the form of group discussions and peer counseling, and could benefit from innovative programming, using video tapes, trips, hands-on experience, etc. Health-related groups could focus specifically on teaching such matters as hygiene and home health practices. Those involved in mental health and education could focus on normal child development, age-related abilities, bonding, stimulation and discipline.

2. That written curricula be developed for these courses.

   This would ensure standardization of course content and, to some extent, its quality. While still dependent on the talents of individual teachers, the programs would be more consistent over time since each class would cover approximately similar material. Again, this would enable evaluation to be done more easily, the goal being the improvement of existing programs and/or the development of new ones.

   The New Jersey Network on Adolescent Pregnancy recommends the following for curriculum development:

   - Adolescent Parenting Education Curriculum, by Judith L. Evans (New York: Manpower Development Research Corporation, Sept., 1985).
   - Teen Pregnancy: A New Beginning, by New Futures (Albuquerque, New Mexico, 1982).
   - Teens Parenting, by Jeanne Lindsay (Buena Park, California: Morning Glory Press, 1985).
   - Getting to Know Your Baby and Yourself, by Child Welfare League of America (New York, n.d.)

G. VOCATIONAL TRAINING

FINDINGS

When community agencies in the survey were asked if they offered vocational training, only ten of 46 (22%) answered affirmatively - and seven of these did not have a written curriculum. The list of topics was reviewed for the three with written curricula and, in the cases of the other seven, questions were asked about the topics that were included.

The table below shows both the range of topics covered and the extent to which they were incorporated into the various educational programs:

TABLE 9: TOPICS ADDRESSED IN VOCATIONAL TRAINING BY TEN COMMUNITY AGENCIES OFFERING VOCATIONAL TRAINING

TOPIC (In Rank Order)	YES	NO
On the Job Follow-Up by Staff Members	10	0
Job Placement	10	0
Work Experience	10	0
Work Behavior	9	1
Employer's Expectations	9	1
Career Alternatives	9	1
Interviewing Skills	9	1
Resume' Writing	8	2
Job Skills	4	6

1. Very few of the community agencies we interviewed offered vocational training. While this might indicate an inadequate sample, we tend to believe in two other explanations: that vocational training was not a priority for those offering services to pregnant and parenting teens and/or that it was an extremely difficult subject for a community agency to undertake.

2. Except for the area of job skills, most programs covered all topics.

3. All ten programs reported that a staff member followed-up those actually placed in jobs.

4. Existing curricula, whether formally written or not, emphasize job readiness and job hunting rather than the learning of specific marketable job skills.

RECOMMENDATIONS

1. That vocational training programs be expanded to this population, preferably through a bold initiative involving collaboration between the state agencies most intimately involved - the Departments of Education, Labor and Human Services.

   Development of vocational education should be expanded to pregnant and parenting teens and, indeed, to all adolescents, in an effort to

cut high youth unemployment. A task force set up by the above departments should develop strategies to teach specific job skills through an expansion of JTPA, traditional vocational education programs and projects sponsored by the Carl Perkins Act. (This Act opens up vocational opportunities to young women.) These bodies have the facilities and personnel needed to impart skills most efficiently and effectively.

In this process, it may or may not be deemed that there is a place for community agencies. Should it be decided that they continue to give services, these agencies must institute closer linkages and joint programming in order to become part of the entire spectrum of services.

2. That specific marketable skills be emphasized in any vocational training undertaken.

   While such items as interviewing skills, work behavior and career alternatives are appropriate, nothing is more important than mastering the specific skills required. If community agencies continue to work in this area, they perhaps should concentrate more on job skills and less on other employment behaviors.

3. That a written curriculum be used by all giving vocational training to ensure program quality and consistency.

   Service providers may want to adapt material from Time for Transition: A Curriculum for Job Training for Adolescent Parents, by Elizabeth A. McGee (New York; Manpower Development Research Corporation, 1985). Continued funding could be contingent upon this point.

4. Auxiliary topics - such as family planning - and child care arrangements should be incorporated into vocational training programs.

   These topics can interfere with the ability of pregnant and parenting teens to find employment. Therefore, programs to make these young parents independent should also attempt to help them solve problems in areas such as deferring future pregnancies and adjusting to the responsibilities of parenting while working. The model developed by Public/Private Ventures, referred to previously, could serve as a working departure for vocational programs (Public/ Private Ventures, n.d.).[1]

H. SERVICES PROVIDED BY COUNTY WELFARE AGENCIES

OVERVIEW

Clearly, CWA's play a critical role for those teen parents needing financial assistance. As part of our study, we were particularly interested in looking at local practices regarding the AFDC application. Informal reports had indicated that all CWA's were not alike, that some

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[1]See the Section on Preventive Services, Section IV, pg. 18.

operated with requirements that delayed timely receipt of AFDC and therefore, Medicaid for newborns. In addition, we were interested in the impact of tighter eligibility criteria recently put into effect by the federal government.

1. Timeliness of applications for AFDC/Medicaid

Findings

Of the 21 CWA's surveyed, six required that applications for newborns be accompanied by a birth certificate before AFDC, and consequently Medicaid, were issued, even when income and asset eligibility were not at issue. The remaining 15 allowed the acceptance of other forms of identification for newborns, such as hospital birthtags, until a birth certificate had been issued.

New Jersey regulations permit the issuance of AFDC when "presumptive eligibility" has been determined. In these situations, a CWA worker verifies all the facts including paternity and accepts proof other than a birth certificate. It should be noted that "presumptive eligibility" cases are considered to be more cumbersome to monitor, and some officials are concerned that this may encourage welfare fraud.

While this is a legitimate concern, it must be remembered that the requirement of a birth certificate delays the infant's receipt not only of AFDC but of Medicaid as well. Delays may have serious health consequences since the infant must a) begin immunizations very soon after birth and b) be monitored frequently for developmental progress in the first few months. A lag of this nature is certainly not cost effective. In immunizations alone, it has been shown that every dollar spent on adequate treatment saves $10 in later medical costs (U.S. House of Representatives, 1985).

Currently, Medicaid regulations prohibit the practice of requiring a birth certificate in order to receive program benefits. A "grace period" is given for infants during which verification other than a birth certificate is allowed so that medical services can begin in a timely manner. Since receipt of AFDC is usually the basis for receiving Medicaid, local CWA practices that require a birth certificate before certifying eligibility for AFDC are inconsistent with federal regulations.

2. "Deeming" of Income

Another AFDC eligibility issue affecting teen parents is that of the "deeming" of family income. That is, the income of all household members is considered when a teen parent's eligibility for the program is being determined. The underlying assumption is that all of the family's income is available for her and the infant's support while residing at home. Consequently, the total family income must be below the stringent AFDC levels before she can qualify for the program. Whether or not the deemed income is actually available to the mother and child is not taken into account. Note that in New Jersey only families with a monthly income of less than half of the

official poverty line are eligible for AFDC. Thus, a working poor family does not qualify for AFDC and, since the totality of their income is deemed to be available to the adolescent parent, neither she or her infant are eligible for financial assistance from AFDC.

One way in which an adolescent from such a family could qualify for AFDC financial assistance would be to leave home and set up an independent household. Another way of coping would be to drop out of school and work to contribute to the family's over-all income. This latter requires some form of child care, usually quite costly, assuming that there is no other caretaker at home and necessitates giving up an education.

In an attempt to assess the results of deeming, the CWA respondents (all of whom were in middle to upper-level management positions) were asked to give their perceptions of the effects of the regulation.

TABLE 10: PERCEPTIONS OF THE EFFECTS OF DEEMING, BY CWA RESPONDENTS

EFFECTS OF DEEMING (In Rank Order)	NO. OF RESPONDENTS WHO:		
	OBSERVED RESULT	DID NOT OBSERVE RESULT	DID NOT KNOW
Teens Established Own Household	13	5	3
Parenting Teens Dropped Out of School	11	6	4
Decline in Family Supports Given to Parenting Teens	10	7	4
Repeat Pregnancy	9	7	5
Increase in Referrals to Help Families Cope with Stress	8	5	8
Increase in Foster Care Placement for Teen's Infant	5	9	7
Increase in Child Abuse and Neglect	4	9	8

N=21

1. Nearly two-thirds stated that more teens were setting up their own households.

2. Slightly over half felt that more teens were dropping out of school.

3. Just under half reported that they perceived a decline in family supports to these youngsters.

4. Interestingly, relatively few reported a perception of increased abuse and neglect.

These perceptions are similar to the findings of others. Research in a number of sources (McGee, 1982; Macker, 1981; Hendricks, 1980) indicates that teens who establish their own households fare worse in terms of education and employment than those who remain at home.

RECOMMENDATIONS

1. That the State Division of Welfare a) officially inform each County Welfare Office that presumptive eligibility should be extended to all newborns eligible for AFDC and b) monitor the way in which this directive is carried out in the individual counties.

   State AFDC regulations, allowing for a grace period of up to 90 days before a birth certificate is required, must be enforced in order to ensure timely medical and nutritional supports to the newborn. The Division of Welfare must be held accountable for the way in which county offices carry out this directive on a class - not case by case - basis.

   In addition, hospital social workers and those working in patient relations on Maternity Wards should be appraised of this regulation so that they can to help needy new mothers make application. Since it is especially critical at this stage of the infant's development, advocates around the state should publicize this information as well as keep track of the manner in which this directive is being carried out.

2. The new Medically Needy Program of Medicaid must be modified also to allow presumptive eligibility for newborns in the some manner, so that vital medical services can be given immediately even though birth certificates have not yet been issued.[1]

   The regulations allowing for out-patient benefits to the needy infant eligible for the program must be changed so that no bureaucratic waiting period is allowed to delay needed medical services. Similar to the AFDC regulations, presumptive eligibility can be enforced, including a 90 day grace period; again, hospital social workers should be made aware of the program and be responsible for helping the new mother apply.

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[1]Effective July 1, 1986, the program extends a selective list of medical benefits - not as comprehensive as those offered by Medicaid - to more of those unable to pay medical costs. It offers a) out-patient medical benefits to needy children to age 21 with income about a third below the poverty line but above the level eligible for AFDC, b) prenatal care and hospital delivery to pregnant woman with similar income levels and c) many out-patient services to the elderly, blind and disabled. Also included is a rather involved "spend down" provision that gives individuals with high medical costs a chance at becoming eligible for the program.

3. Attempts to modify the federal deeming policy must be made by State advocates.

Since the results of the policy are so negative to the futures of the new mother and infant, New Jersey advocates must join with those from other states to press for a rescinding of the policy. Research findings must be used to show legislators and the administration that what at first seemed to be a deterrent to adolescent pregnancy actually increases the chances of future dependency and social expenditures of all kinds. It encourages school dropouts, provides an impetus to leaving home and decreases family supports, all shown to be harmful to the new family.

III. TRAINING OF STAFF

OVERVIEW

In our survey, we were interested in the amount of training given to staff in the areas of human sexuality and adolescent development, for they result in increased skill and morale. Training was broadly defined to include half-day training sessions, seminars and conferences of several days' duration.

FINDINGS

Respondents from 46 community agencies and 20 DYFS offices were asked about the training that their staffs had received in the past year in human sexuality and adolescent development.[1] Thus, a total of 66 were interviewed, of whom half (33) reported that there had been no such staff training in the past year.

Half or thirty-three of the respondents indicated that they had received training in either human sexuality or adolescent development but only four reported training in both areas. It will be recalled that training could have been received in many ways, at conferences, seminars and training sessions, as well as at more formal course offerings.

RECOMMENDATION

That staff training in the areas of human sexuality and adolescent development be routinely offered by every agency working in teen pregnancy.

Since lack of training has serious consequences for quality service delivery, staff members should be offered and required to expand knowledge bases and upgrade their performances. We recommend the seven-week "Changing Bodies, Changing Lives" and material on inter-related adolescents issues developed by the New Jersey Network on Adolescent Pregnancy. The recommendations contained in the previous section on primary prevention apply here as well.

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[1] School personnel were asked a different set of questions. See prevention section.

IV. EVALUATION

OVERVIEW

In recent years there has been increasing recognition of the worth of evaluating agency performance. By gathering data on exactly what the outcomes of service are, and then setting up objective criteria by which to evaluate these outcomes, providers should be able to judge the effectiveness of their services. This can lead subsequently to informed decisions as to where and how improvements can be made.

Knowing this connection between evaluation and improvement, we were interested in determining whether or not the responding agencies were monitoring the following outcomes: 1) number completing the service; 2) number completing high school; 3) number employed; 4) birthweight of infant and 5) number of repeat pregnancies. (These are suggested in a report by the Southwest Regional Laboratory, 1984.)

As indicated in Table 11, the majority of our respondents did not monitor these outcomes. Perhaps most striking is the fact that so few - only 12 agencies or 21% - monitored the number completing their own service. Note that our findings are similar to those reported by the U.S. House of Representatives Select Committee on Children, Youth and Families in a national survey of services to pregnant and parenting teens published in 1986. They also found a lack of consistent evaluation.

TABLE 11: EVALUATION DATA COLLECTED BY COMMUNITY AGENCIES AND SCHOOLS FOR PREGNANT TEENS

TYPES OF EVALUATION DATA	YES	NO	TOTAL
Number of Repeat Pregnancies[a]	19 (34%)	37 (66%)	56 (100%)
Number Completing High School	13 (23%)	43 (77%)	56 (100%)
Number Completing Service	12 (21%)	44 (79%)	56 (100%)
Number Employed	6 (11%)	50 (89%)	56 (100%)
Birthweight of Infant	5 (14%)	31 (86%)	36[b] (100%)

N=10 Schools, 46 Community Agencies

[a]Respondents from the 20 community agencies that provide primary prevention were asked whether they collected information on first pregnancies.

[b]The 20 community agencies providing primary prevention were excluded, with the result that the total of agencies is 36.

Absence of monitoring can stem from a number of causes: It can come from a lack of funding, can show an absence of clear goals or a belief that service-giving is the only important activity. It can also come from little awareness of the need to develop a plan to effect changes in an entire system rather than in one case. For example, if the number of dropouts among

recipients is not monitored, service providers may not be aware of the need to develop new strategies to keep their own clients in school. On the other hand, if the rate of high school completion for an entire district or county is not looked at, service providers are probably not addressing the problem as it affects all pregnant/parenting teens in their area. In the latter case, something can be done only by banding together with others and attempting comprehensive interventions along a spectrum of programs and services to all students, not only individual clients.

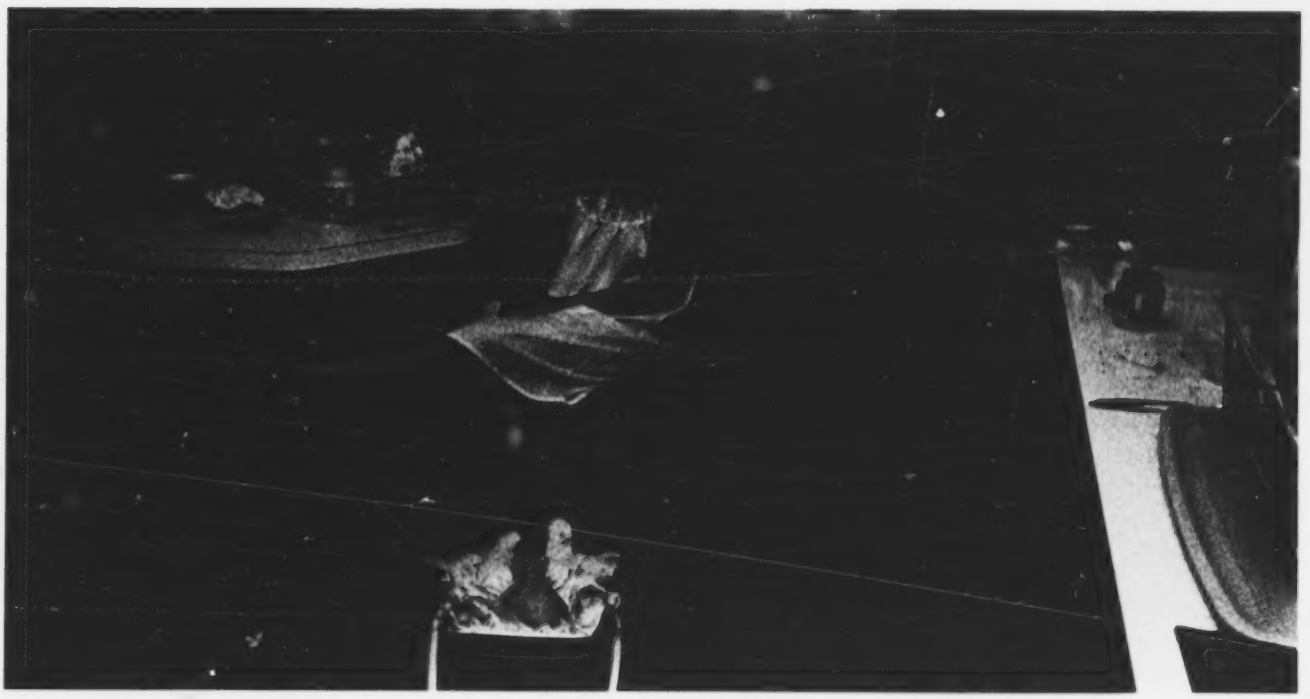
RECOMMENDATIONS

1. That all programs monitor at least the five following outcomes: a) number completing service; b) number completing high school; c) number employed; d) number of repeat pregnancies and e) birthweight of infant.

   Funding sources should require this effort in return for financial support. They should provide technical assistance so that data is gathered in a reliable fashion. Help should be offered so that the agency can collect other valid data if so desired. Individual workers must be made aware of the fact that evaluation is an integral part of their duties to be performed in a timely fashion. Systems for efficiently gathering the data should be established in each agency so that it becomes a routine operation.

2. That methods to help analyze the collected data and develop plans to improve services be established on a regional or state-wide basis by regional groups, county and/or state agencies, etc.

   Meetings, seminars and workshops should be convened to help agencies with data gathering and analysis. Subsequent conferences and workshop should address problems found by the evaluation, so that it will lead to improvement of existing services.



UNMET SERVICE NEEDS TO YOUNG FAMILIES

OVERVIEW

The New Jersey Network on Adolescent Pregnancy (NJNAP), co-sponsor of this project, was organized in the winter of 1979 as a voluntary association of organizations and individuals focusing on the issue of teen pregnancy. By the summer of 1982, the State Network - working out of offices in the Center for Community Education of the School of Social Work at Rutgers University - had local Networks established in all 21 counties.[1] The thrust of the organization's efforts has been to enhance and support the work of these individual County Networks as well as the local agencies and groups active in providing both prevention and treatment services.

1982 NEEDS ASSESSMENT OF NJNAP

At a 1982 general meeting, representatives from 16 of the 18 County Networks responded to a survey that elicited their views on problems they encountered and possible solutions that could be implemented in their specific counties. In terms of problems, both in prevention and treatment, the respondents listed a lack of funds as paramount. Without adequate backing they found it difficult to conduct all aspects of their work.

In assessing gaps in service at that time, the respondents listed major unmet needs (in rank order, with number one being the highest priority): 1) Housing; 2) Infant Child Care; 3) Parenting Education and 4) Services to Teen Fathers

Also mentioned but with lower priority were such items as job training, transportation and family planning. Least often mentioned were gaps in health and medical care, recreation and adoption services. However, the major unmet needs seen by these service providers were those four enumerated above, all of them related to treatment.

FINDINGS ABOUT UNMET TREATMENT NEEDS

Did the respondents to our present 1985 survey support or refute the previous assessment? We asked the respondents - in both prevention and treatment services - if they agreed with this list of major unmet needs. The question was motivated by the realization that our respondents might see other priorities as a result of their own unique experiences and also by the fact that changes since 1982 may have made some or all of the earlier opinions outdated.

In addition, two other questions about this issue were asked. The first asked the respondents if they thought they could meet any or all of the needs listed and, where the answer was affirmative, whether they would use existing resources or would need additional ones in order to do so. The following table shows their responses:

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[1] In two counties there were joint County Networks.

TABLE 12: RESPONDENTS' ASSESSMENTS OF UNMET NEEDS AND THE FEASIBILITY OF DEVELOPING APPROPRIATE SERVICES

UNMET NEEDS	FEASIBILITY OF DEVELOPING NEEDED SERVICES[a]			
AREA	AGREE WITH NETWORK	YES, WITH EXISTING RESOURCES	YES, WITH ADDITIONAL RESOURCES	NOT FEASIBLE TO MEET NEED
Housing[b]	100%	4%	30%	66%
Infant Day Care	100%	25%	30%	45%
Parenting Education	100%	31%	33%	36%
Services to Teen Fathers[c]	100%	41%	33%	26%

N=111

[a]The 14 FLE educators were excluded since they were not directly responsible for treatment services. The N, therefore, in this category is 97.

[b]The 10 respondents from schools for pregnant teens are excluded since provision of housing is not within the public school's mandate. Similarly, the 20 community agencies providing primary prevention were excluded.

[c]The community agencies providing primary prevention services were asked about the feasibility of involving males.

FINDINGS

1. All our respondents agreed with the 1982 assessment by Network members as to the priority areas of unmet needs.

2. Two-thirds of the respondents felt that they could not meet the housing needs of pregnant and parenting teens, even if additional resources were made available. Clearly, the housing issue was perceived to be the most intractable.

3. Over half said that they could provide infant day care either with existing resources or with additional ones. However, just a little less than half felt that they could not develop services to meet the need.

4. Two-thirds felt that they could develop courses on parenting education, half of them with resources already at their disposal. Only a third of the respondents felt that they could not develop such classes.

5. About three-quarters of the respondents answered that they could develop services to teen fathers, more than half of these with present resources. Obviously respondents judged this to be the area easiest to address.

It is most interesting that every one of the respondents concurred with the priorities listed in the 1982 assessment of need. What this indicates is that there has been little if any change in the situation. Moreover, the original assessment was seen as valid by workers other than those who made it, indicating that it was not the biased response of an unrepresentative few.

In analyzing the priority rankings of these responses, it becomes apparent that the needs judged to be the most difficult to satisfy are those that reflect larger problems affecting the total New Jersey community. Thus, housing and day care needs (specifically infant care), seen as the most difficult to redress, are critical for all low-income families and/or working mothers in the state. Does that mean that these high-priority needs of adolescent families must await solutions aimed at the larger population? We believe that that cannot be, that the unmet needs of teens which are entwined with those of the larger community must be dealt with separately in an expedited fashion. They must be isolated from the generic problems and worked on in the context of adolescent needs alone, if there is a serious intent to achieve progress in dealing with teen pregnancy and parenting.

HOUSING NEEDS

In the area of housing, workers indicate that many pregnant and parenting teens are told that they cannot remain at home, others have no homes, while still others must initiate a move for a variety of compelling social-psychological-financial reasons. Their needs cover the spectrum, from short-term, emergency forms of shelter to long-term housing for up to two years after the baby's birth. The settings themselves can be varied: from a parent's home to a group home, from an independent living arrangement to a maternity home to a foster-care placement. Any or others could be chosen depending upon their availability and suitability, given the young woman's age, her capabilities, psychological and medical situation and the extent of family supports.

As discussed above, two-thirds of the respondents felt that they could not meet housing needs in any way. However, this pessimistic response should not be taken as a sign that solutions or even partial solutions cannot be found. First of all, almost a third of the respondents (12 from DYFS, 8 from community agencies and 5 from CWA's) felt that, with the addition of new resources, something about the issue could be done. Second, we believe that if the provision of resources were restructured, much - if not all - of the housing need could be met.

RECOMMENDATION

That a state initiative be carried out expressly to provide housing alternatives of various kinds - foster placements, group homes and semi-supervised independent living programs - for pregnant and parenting teens who need shelter.

It must be noted that the housing situation cannot change without the infusion of additional resources. Merely coordination or cooperation will not work where the supply of individual units, facilities and/or placements simply does not exist.

INFANT CHILD CARE NEEDS

The need for infant day care, second on the priority list, is also critical, and current estimates of need may be gross understatements. In fact, whereas some of the teens may be able to solve their housing needs by moving in with friends and relatives, it is much more difficult to arrange infant care in order to continue schooling.

As more and more women enter the labor force, the supply of alternate caretakers within the family or neighborhood diminishes. Finding a child care center is extremely difficult. Very few are equipped to care for infants; where such

centers do exist, they are expensive and subsidized slots are increasingly difficult to come by. A recent four-county survey by the New Jersey Network found that of 82 centers, only four (5%) provided care for babies at six months! The author stated that "long waiting lists and targeted eligibility requirements severely restrict the number of infant day care slots." (Wilson, 1984-85)

Rather than a center, care might be found in a Family Day Care Home, i.e., a private home where the head of the house provides the service. In fact, it is generally believed that the majority of infant care is provided in homes of this type, the number of which is not known since most of them operate without official sanction, declaring no income and paying no taxes. We do not know the number of slots used by adolescents for their infants. In New Jersey there is as yet no body of licensing regulations to which these homes must conform.[1] A number of homes are affiliated with the new Family Day Care Association (see below); these are usually not-for profit with a sliding-fee-scale and some subsidy. Generally, the prices paid for care in Family Day Care Homes are not regulated; it is assumed that the cost is lower than in centers. However, it still may be too expensive for the teen.

The third form of infant care that might conceivably be utilized is the special child care center that is on a school site or nearby, specifically set up so that the student mothers can continue to attend class. In spring, 1985, contacts with those providing this service indicated that only five such special programs, state and/or locally funded, existed in New Jersey - in Voorhees, New Brunswick, Elizabeth, Newark and Englewood.[2] These centers not only offer infant and child care while the mother is in class but also provide parenting and nutrition classes, while one is focused specifically on teaching skills to avert child abuse.

Workers in the field strongly feel that there is a critical shortage of child care services - particularly for infants - that would enable a young mother to continue in school or to return after delivery. We attempted to document this shortfall in supply by asking educators in six urban districts how many pregnant teens were being educated in alternate arrangements such as home instruction and/or after-school programs. This question was predicated on the observations of teachers and workers, that the students tended to drop out of regular classes once their pregnancy became visible, making alternate educational programs necessary. On the average, each of these six educators stated that 40 young women were in such programs during the 1983-84 academic year. On the other hand, DOH statistics for that time period on births to teens 17 and under in these cites, show that at least 150 babies were born in each locality. If the preponderance of pregnant students dropped out of regular daytime classes and so few were enrolled in alternate classes, where did the others go?

A number of study respondents were of the opinion that many of the teen mothers had dropped out of school <u>before</u> becoming pregnant, an explanation that has been confirmed in other localities by several empirical studies (Polnit, 1985;

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[1]Legislation on registration - not licensing - is pending in the Legislature. The recently established NJ Family Day Care Association has developed industry standards and as of January, 1984, 550 homes participated, adhering to their guidelines. Membership, which is voluntary, carries with it the stipulation that each home can have no more than two children under the age of 23 months.

[2]This may not cover all such programs but serves to illustrate how few there are.

University of California at San Francisco, n.d.; McGee, 1982). Surely this would explain the discrepancy between enrollment and birth statistics. If that is to a large extent true, the explanation still does not diminish the necessity to encourage all young women to stay in school - whether they be low achievers, pregnant and/or young mothers. All agree - and research confirms - that under present conditions a high-school diploma (or a G.E.D.) is a necessary precondition for employment. To assure their ability to become independent, young women must be encouraged to finish their education. And for most of those with children, child care - and specifically infant care - will make it possible to earn a diploma.

RECOMMENDATION

That infant day care slots be opened specifically for parenting teens on the condition that they remain in or return to school until graduation or receiving a GED.

This care could be based in traditional centers, in family day care homes or in special school centers. The latter appear to be the most suitable, because of proximity to the educational institution and because classes to teach parenting skills could be easily arranged. Funding could be a joint endeavor, involving DYFS and the state Department of Education with some local contribution if possible.

THE NEEDS FOR PARENTING EDUCATION AND SERVICES TO TEEN FATHERS

Both these topics have already been discussed in the Treatment Section with extensive recommendations. In our data, as previously stated, these two areas of need were judged to be the easiest to address, even with existing resources. Although not universally recognized as important, they contribute greatly to the stability and wellbeing of the young family and are, perhaps, second only in importance to employment, housing and infant day care.

THE NEED FOR INFORMATION: DATA-GATHERING IN THE SCHOOLS

This need was not addressed in interviewing but found in the process of data gathering. In comparing statistics on the number of pregnant students enrolled in a school versus the number of teen births, it became very apparent that school authorities pay little attention to this issue. There was underreporting of pregnancies and lack of consistent, reliable data. Perhaps the problem stemmed from the fact that there was no central body in the school responsible for such data-gathering; perhaps the problem occurred because the State Department of Education did not delve into the issue thoroughly. For whatever reason, school officials had little knowledge of the number of girls each year or semester who were pregnant; who, because of pregnancy, dropped out, continued in regular class and/or transferred to a special class; who returned after child birth; or who, after returning, continued on to graduation.

RECOMMENDATION

That the local schools under the leadership of the State Department of Education, gather the information in a systematic, on-going fashion, naming a responsible agent in each junior or senior high school. Armed with correct and up-to-date information, the departments could help evaluate the efforts undertaken to counter this young-parent, drop-out syndrome.

A LEAD AGENCY PROPOSAL

The previous pages leave the reader with one overall impression -- that there is a lack of coordination between and among the various parts of the system attempting to address the phenomenon of adolescent pregnancy. In fact, it may be a mistake to call it a system, since it lacks any semblance of a unitary whole. A new approach is needed, one that will a) coordinate existing services in New Jersey so that they form a comprehensive and complementary whole and b) develop plans on a state-wide level to improve present prevention and treatment efforts and, at the same time, create new initiatives to satisfy unmet needs. All of this should be done within the context of the adolescent as a member of a distinct age group with specific characteristics, occupying a unique position in today's society.

The boundaries of service delivery systems will have to be eased so that they can work together to provide a wide spectrum of services in which prevention and treatment will be intergrated so as to form a continuum of care. Bonds will have to be formed to coordinate the diverse efforts and initiatives of the various state departments.[1] And beyond the practical difficulties of achieving a comprehensive approach in the current climate is the fact that the system is structured around the categorical needs of adults and children, who - for all practical purposes - are pre-adolescents. An inherent problem is the absence of age-appropriate services.

Gaining cooperation, attaining coordination and addressing the adolescent as a distinct age category with unique requirements are the major issues. To that end, we pose the following recommendation:

RECOMMENDATION

That a state department be designated as a lead agency within which an Office of Adolescent Services be developed to deal with the problems of adolescent pregnancy in the following manner:

- To be responsible for coordinating the myriad of health, education, employment and social services required to prevent adolescent pregnancy and to help our youngest families. As part of its coordinating function, this office would be given authority 1) to develop a comprehensive plan for preventive and treatment services and 2) to coordinate all budget requests and evaluation.

- To assume primary responsibility for ensuring that service providers receive appropriate technical assistance in the following areas: 1) the use of comprehensive intakes; 2) the development of outreach, follow-up and case management approaches; 3) the enhancement of staff performance through

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[1] We recognize the intra and interdepartmental efforts already underway - The state agencies network with Division of Public Welfare leadership; and the designation of adolescent pregnancy as one of the six priority areas for FY87, by the DHS-State Human Service Advisory Council. Even before the priority designation, two county HSAC's had targeted funds to adolescent pregnancy and teen parenting. Thus, precedent is set to encourage other counties to target pregnant and parenting adolescents for Human Services funding.

training; 4) the strengthening of linkages among service providers for referral, resource sharing and joint programming; and 5) the monitoring of critical outcomes. Feedback from the results of these activities should be continuously used for planning to meet unmet needs.

- To develop a strategic long-range plan; to solicit, accept and disburse grants to local programs for both prevention and treatment; to develop a public information campaign and coordinate community education programs; to stimulate the expansion and/or addition of programs; and to make recommendations regarding any needed executive or legislative action.

Bearing in mind that gaining cooperation and attaining coordination are major issues, we assessed the probabilities of each state department in meeting these goals.[1] In brief, we found the following:

- State Department of Education - It mandates FLE, the major public program devoted to prevention. However, the department has given it no appropriations -not for curriculum development, not for teacher training, not for model program implementation. Further, there is no clear state policy on managing pregnant adolescents in the public school system, leaving most school districts to develop responses - mainstreaming, alternative programs or home-tutoring - on their own. Our experience is that this most often leads teens to fend for themselves. We have also been alerted to the fact that the department is reviewing the classification system for special education categories, and there is fear that pregnant adolescents may be dropped, thus eliminating any possible education funding for alternative school programs.

- Department of Human Services - While it has a good record in the number of treatment programs being funded, it has yet to create a concerted, intra-departmental approach to the issue. This is understandable since the priority areas are child protection/child abuse, neglect and abuse prevention in the field of child welfare (DYFS), and public assistance in the Division of Public Welfare. These are two categories in which most pregnant adolescent or teen parents do not fall. More importantly, teens are notoriously reluctant to seek services and their hesitation is confounded if they perceive services as only "for them" (the poor) as is the case when programs are administered through the public assistance and child welfare systems. Further, the negative stereotypes, coercion and stigmatizationn of welfare and child protective service systems perceived by both service recipients and the public alike has been well documented (Feagin, 1974; Briar, 1966).

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[1]While we are mindful of the role of the Department of Corrections, the Department of Labor and the Division on Women in addressing adolescent pregnancy, teen parenting and prevention, the number of these particular adolescents with which they work with is so small that we did not consider those units as a possible lead agency.

- The State Department of Health - Its public health mission has long been apparent in their providing non-categorical services to all who need family planning, to all mothers and children, and to all individuals and families in need of substance abuse prevention and treatment programs. This universal approach is particularly important in serving teenagers who have a variety of needs. The size and manageability of the DOH would also make it attractive in administering an adolescent - specific program. The service model necessary to provide targeted programs has its precedent in the State Department of Health - Special Child Health Unit. This county-based services and case-management program has a record of identifying, monitoring and servicing a special population. This model could be replicated, in a separate unit, with its own funding, to provide services to adolescents. However, the DOH is a rather small department with limited fiscal and personnel resources, and has not had extensive experience in working with adolescents beyond fulfilling their specifically health-related needs.

In summary, these are strengths and weaknesses in each of the State Departments when we come to consider developing something along the lines of an Office on Adolescent Services to provide services for pregnant and parenting teens and those at risk. We hope that there will be serious consideration of this recommendation and the sponsoring organizations will seek to convene an interdepartmental meeting to discuss this.

We feel confident that a contractual arrangement/affiliation agreement can be worked out among the key actors in the various systems that would reduce the discontinuities among the state departments and enhance their implementation to address the inter-related issues facing pregnant and parenting teens and those at risk. We support the creation of a bi-partisan, blue-ribbon Task Force on Adolescent Pregnancy to assure the `fit´ between state agency programs, community services and legislative and executive initiatives.

APPENDIX: OVERVIEW OF OTHER STATE LEGISLATIVE TRENDS[1]

Just as New Jersey's Family Life Education policy is the first of its kind and a model for programs elsewhere, many other states, the District of Columbia and national associations are generating and implementing innovative new ideas to deal with adolescent pregnancy and parenting.

NATIONAL STUDIES

As an aftermath to the cross-national study released by the Alan Guttmacher Institute in spring, 1985 -- which showed that the U.S. had the highest rate of adolescent pregnancy in the industrialized world -- several national studies were initiated. The National Governor's Association, the National Association of State Legislators and The Select Committee on Children, Youth and Families of the U.S. House of Representatives all surveyed governmental, legislative and programmatic policies and services -- each from their own perspective -- and published reports with findings and recommendations.

TASK FORCES

The major legislative initiative in the past 18 months has been the creation of blue-ribbon Task Forces in other states, including the three states in the metropolitan area.[2] Connecticut, the District of Columbia, Maryland, Massachusetts, New York, North Carolina, Pennsylvania and Wisconsin have all created bi-partisan, multi-constituency approaches to exploring the issues and creating legislative agendas. The Task Forces have brought the issue of adolescent pregnancy and parenting to the public's attention, generating both public support and funding.

LEGISLATION

North Carolina, which had the first Task Force, recommends the State Department of Health as the lead state agency in administering, budgeting and coordinating programs for pregnant and parenting adolescents. North Carolina has also appropriated almost $2.M to support community-based programs such as school-based clinics and targeted counseling and education programs. Thus far, 16 counties have received up to $60,000 each for special projects.

Massachusetts -- which has an Office on Adolescent Services in its State Department of Health -- has focused on a public-private jobs collaboration for high-risk teens. This includes in-class career planning, part-time school year and full-time summer employment, counseling, and jobs after graduation. Connecticut has pending legislation to replicate the Massachusetts' model.

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[1]Written by Ann M. Wilson, Assistant Professor, ACSW, Coordinator of the New Jersey Network on Adolescent Pregnancy at the Rutgers University Center for Community Education.

[2]As we go to press, the New Jersey Senate has passed the Lipman-Garvin legislation establishing a Task Force on Adolescent Pregnancy in New Jersey and sent the amended bill back to the Assembly.

Maryland is starting a controversial economic incentives program to high-risk girls between 15 and 18 years old to encourage them to complete school and avoid pregnancy. While such programs have been criticized by some as bribing young people to do what they should be doing as a matter of individual responsibility and self-interest, many people feel that for too many high-risk teens there are few economic disincentives to early childbearing. Maryland's approach has worked successfully in three Baltimore projects that provide jobs as incentives and rewards for meeting school attendance and achievement criteria.

While it included innovative approaches about contraceptive accessibility for teens and increased advertising of non-prescription contraceptives, Wisconsin's legislation has received most of its publicity around its "parental responsibility" provision that calls for legal liability to be imposed on both the girl's and partner's family in the event of a pregnancy -- rather than immediate eligibility for public assistance.

The report from the Massachusetts Task Force included the most far-reaching discussion and recommendations on infant day care, in that it not only specified services unique to teen parents, but also touched on changes needed within the day care system itself. Connecticut and the District of Columbia are considering funding for school-based day care facilities.

Finally, New York State's Task Force -- with the Governor's wife as the honorary chairperson -- has resulted in legislation allocating some $5.M annually to programs for pregnant adolescents, for teen parents and for prevention. New York has initiated an innovative JPTA project that combines job training, child care and reproductive counseling for teen parents. On the local level, New York City initiated a city-wide blue-ribbon Task Force[1] that resulted in the creation and funding of inter-agency Networks in all five boroughs. Priorities of these Networks have been jobs, infant day care and services to teen fathers.

These are only a fraction of the legislative initiatives now being implemented or considered across the country. Their diversity signifies not only a broad-based effort to develop an effective response but also the realization that adolescent pregnancy is a social responsibility as well as a social crisis that requires both public and private intervention and a comprehensive approach.

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[1]Also as we go to press, the City of New Brunswick has just established a city-wide Task Force on Adolescent Pregnancy.

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